HEALTH CARE TAX CREDITS TO DECREASE THE NUMBER OF UNINSURED

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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HEALTH CARE TAX CREDITS TO DECREASE THE NUMBER OF UNINSURED

WEDNESDAY, FEBRUARY 13, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 11:25 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 6, 2002
No. FC–14

CONTACT: (202) 225–1721

Thomas Announces a Hearing on Health Care Tax Credits to Decrease the Number of Uninsured

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on the President's proposal to reduce the number of uninsured through tax credits. The Committee will also examine other tax credit proposals, such as the one that passed the House in December. **The hearing will take place on Wednesday, February 13, 2002, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Bush Administration experts on health care tax credits and proposals to help reduce the uninsured population. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing

BACKGROUND:

On February 4, 2002, the President submitted his fiscal year 2003 budget to the Congress, which included a refundable, advanceable tax credit for the purchase of health insurance. This initiative addresses the fundamental, chronic, institutionalized uninsured problem in America. Despite recent declines in the total number of uninsured—38.5 million in 2000, down from a high of 44 million in 1998—the prospects for a continued and sustained rise in the uninsured have grown with the resurgence of double digit health inflation and a war-weakened economy.

Premiums for employer-sponsored health insurance increased 11 percent last year, the largest increase in recent years, and projections for the near future peg health inflation even higher. As health costs are the primary reason most people forgo insurance, the return of double-digit health inflation will likely exacerbate the uninsured problem. Because most individuals obtain health coverage through their employers, the combination of higher premiums and recent increases in unemployment mean providing increased access to affordable insurance policies will prove more challenging and requires more creative solutions.

In December of 2001, the House passed economic stimulus legislation (H.R. 3529, the "Economic Security and Worker Assistance Act of 2001") that included an advanceable, refundable tax credit for the purchase of health insurance. That bill would provide a 60-percent credit for the purchase of qualified insurance policies for those involuntarily terminated from their jobs. Individuals would have the choice to stay in their employer-sponsored COBRA policy or to purchase a policy in the individual market. The President's 2003 budget provides a $1,000 credit for individuals and up to $3,000 for families for the purchase of qualified policies up to certain income limits.

In announcing the hearing, Chairman Thomas stated: "This hearing will help lay the groundwork for insuring all Americans. Because nearly 40 percent of uninsured adults and 25 percent of uninsured children have no regular source of health care, they receive less health care and often resort to more costly interventions such as inappropriate emergency room utilization. While it was unfortunate the Senate failed to act on any uninsured proposal, I am committed to working with Republicans and Democrats and the Administration to ensure access to quality, affordable health insurance."

FOCUS OF THE HEARING:

The focus of the hearing is to review various proposals to provide a refundable tax credit for the purchase of health insurance, including the President's proposal.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *"hearingclerks.waysandmeans@mail.house.gov",* along with a fax copy to 202/225–2610 by the close of business, Wednesday, February 27, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the full Committee in room 1102 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse unopened and unsearchable deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *"hearingclerks.waysandmeans@mail.house.gov",* along with a fax copy to 202/225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*** * * NOTICE—CHANGE IN TIME * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 11, 2002
No. FC–14–Revised

CONTACT: (202) 225–1721

Change in Time for Hearing on Health Care Tax Credits to Decrease the Number of Uninsured

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the full Committee hearing on health care tax credits to decrease the number of uninsured scheduled for Wednesday, February 13, 2002, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will be held instead at 10:45 a.m.**

All other details for the hearing remain the same. (See full Committee Advisory No. FC–14 released on February 6, 2002.)

Chairman THOMAS. Good morning. I would like to welcome our witnesses and guests to today's hearing. I apologize for the lateness of the beginning of the hearing. There was necessary administrative business that had to take place.

Today's hearing is an important one on how to make health insurance more affordable, specifically for displaced workers but also for those who do not have health insurance. As we know, a million Americans have lost their jobs since September 11, and when people lose their jobs, if they had it, they lose their health insurance coverage.

Some 40 million Americans are uninsured. When the uninsured receive their medical care but can't pay for it, pretty obviously they get the care but the costs are shifted to others. Exacerbating the problem is that same uninsured individual's tendency to deal less in preventive care and often resort to the most expensive kind of medicine, emergency room use of a doctor of last resort.

Six weeks ago now the House passed legislation providing unemployed workers access to the health insurance of their choice. If the Senate had acted, millions of unemployed, uninsured workers and their families would already be receiving a 60 percent refundable and advanceable tax credit to assist them in purchasing the health insurance that best fits their family's needs. Unfortunately, the response that we got from the Senate was for the last century's response of unemployment insurance.

I think three fundamental principles should govern our solution to this problem: One, obviously availability; two, affordability; and, as much as possible, allowing consumer choice. The Displaced Worker Tax Credit I believe meets all of these principles.

The tax credit is refundable. That means even people with little or no tax liability receive assistance to purchase private health in-

surance. The tax credit is also advanceable. That means assistance is provided when it is needed, and individuals don't have to wait until the end of the year to get a refund check from the Internal Revenue Service. And, most importantly, it allows individual to choose the health care that best fits their family's needs, whether they choose to stay with their former employer's plan or opt for a new, perhaps more affordable one.

The President's budget reserves over $100 billion for two new health insurance tax credits, credits for all lower- and moderate-income uninsured individuals, and the Displaced Worker Tax Credits which passed this House in December.

The Displaced Worker tax credit is a large umbrella. If you have lost your job, you are eligible. It will cover all those who find themselves unemployed through no fault of their own, not just people who were lucky enough to have insurance while they had a job. It helps everyone, but particularly those at the lowest income level.

The broader uninsured tax credit is specifically targeted at lower- and moderate-wage earners without insurance, because on their jobs they don't have that insurance. It recognizes the diversity of the uninsured and allows them to purchase the health plan that is best for them.

Passing the problem off to the States, already struggling with skyrocketing Medicaid costs, is probably not the answer. Forty States are running budget deficits and six are not even in session this year. The prospect that these States would magically expand Medicaid, fundamentally a welfare program for the poor, to middle-class individuals is I think a long shot at best.

Health insurance for the unemployed should be just one component of a modern health care system that offers choice, independence, and the ability to tailor to your particular and specific needs. But the real answer is to restore our economy to full health, creating the jobs and paychecks that will get displaced workers back on their feet. They still may, however, have a job but no health insurance.

[The opening statements of Chairman Thomas and Mr. Ramstad follow:]

Opening Statement of the Hon. Bill Thomas, a Representative in Congress from the State of California, and Chairman, Committee on Ways and Means

Good morning. I'd like to welcome our witnesses and guests to today's hearing on how to make health insurance more affordable for displaced workers.

A million Americans have lost their jobs since September 11.

When people lose their jobs, they often lose their health insurance coverage too. Now, nearly 40 million Americans are uninsured. When the uninsured receive medical care but can't pay for it, the costs are shifted to others. Exacerbating the problem is that these same uninsured individuals tend to receive less preventive care and often resort to emergency rooms as the doctor of last resort.

Six weeks ago, the House passed legislation providing unemployed workers access to the health insurance of their choice. If the Senate had acted, millions of unemployed, uninsured workers and their families would already be receiving a 60% refundable and advanceable tax credit to assist them in purchasing the health insurance that best fits their families' needs. We are still waiting for the Senate to act.

Three fundamental principles should govern our solution to this problem: availability, affordability, and consumer choice. The displaced worker tax credit meets all those goals.

The tax credit is refundable—that means even people with little or no tax liability receive assistance to purchase private health insurance. The tax credit is advanceable—that means assistance is provided when it is needed, and individuals

don't have to wait until the end of the year to get a refund check from the IRS. And most importantly, we trust individuals to choose the health care that best fits their families' needs, whether they chose to stay with their former employer's plan or they opt for a new one.

The President's budget reserves over $100 billion for two new health insurance tax credits: credits for all lower and moderate income uninsured individuals and the displaced worker tax credits, which passed the House in December.

The displaced worker tax credit is a large umbrella: if you've lost your job, you're eligible. It will cover all those who find themselves unemployed through no fault of their own, not just people who were lucky enough to have insurance while they still had a job. It helps everyone, but particularly those at the lowest income level. The broader uninsured tax credit, is specifically targeted at lower and moderate wage earners without insurance, because their jobs don't offer health care. It recognizes the diversity of the uninsured, and allows them to purchase the health plan that is best for them.

Passing the problem off to the states—already struggling with skyrocketing Medicaid costs—is not the answer. Forty states are running budget deficits and six are not even in session this year. The prospect that these states would magically expand Medicaid, a welfare program for the poor, to middle class individuals is a long-shot at best.

Health insurance for the unemployed should be just one component of a comprehensive modern health care system that offers choice, independence and the ability to tailor care to your specific needs. But the real answer is to restore our economy to full health, creating the jobs and paychecks that will get displaced workers back on their feet.

Before proceeding to our witnesses, I would ask the Ranking Member, the gentleman from New York, if he wishes to make an opening statement.

Opening Statement of the Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this important hearing and for your strong leadership on decreasing the number of uninsured Americans through tax incentives.

The President's health insurance tax credit proposal and the similar provision the House passed in December in the "Economic Security and Workforce Assistance Act" would go a long way toward providing uninsured Americans with the health insurance they so desperately need.

Over 40 million Americans currently have no health insurance. With a weakened economy and double-digit health care inflation, this crisis is not likely to improve without bold action.

President Bush and this Committee are providing the leadership needed to tackle this issue. We must examine creative ways to give more Americans access to quality, affordable health care.

I also want to compliment the Bush Administration for its proposal concerning Flexible Spending Accounts (FSAs), which allow workers to save for future health care costs. The President's proposal is similar to legislation I introduced, H.R. 1590, which allows workers to roll over $500 from one year to the next instead of forfeiting their FSA balance at the end of the year. This reform will encourage workers to save for health care expenses and make smart purchasing decisions.

I certainly look forward to hearing from the witnesses today about ways to address the crisis of uninsured Americans, and once again, thank you, Mr. Chairman.

Chairman THOMAS. Now, prior to calling on our witnesses today, the Chair would recognize the Ranking Member, the gentleman from New York.

Mr. RANGEL. Thank you, Mr. Chairman.

It seems like it was only yesterday that the leadership of this august Committee was contemplating pulling up the Tax Code by its roots. One of the reasons was the tax credits and the things that made the Code so complicated. Of course, when you think of the

political priorities as to whether or not we would want to simplify the Tax Code or whether we would want to destroy employer-based health plans, then we have to decide which is the priority and which way that we are going to go.

It just seems to me that even when we talked about the stimulus package, that we could have found an uncomplicated way to do it on a temporary basis, and we can move on with these hearings to see whether or not the system that you are recommending or the Administration has recommended is employee-friendly, whether it gives older folks an equal opportunity, as well as people who are not that healthy. In any event, Mr. Stark has developed an expertise in this area as the Ranking Member of the Health Subcommittee, and with your kind permission I would like to yield to him, and I might add for the Chairman's comfort, just to him.

Mr. STARK. Thank you, Mr. Chairman and Mr. Rangel.

The issue today of the health insurance tax credit is important to all of us, and most important I suppose to the 40 million Americans who go today without health insurance, which means basically in this country they don't get health care. It need not be a partisan issue. Obviously there are some great philosophic differences here.

And I am concerned that this hearing should focus not on the goal, is going to focus not on the goal of helping the uninsured get insurance, this hearing is going to focus on tax credits, whether they solve the problem or they don't. And we have much research to show that health care tax credits create more problems than they solve, unless in fact they are universal and come with strict controls on the health insurance industry, which is not suggested.

The choice of—well, we will see some research that Professor Gruber will give us, that shows that under the health tax credits we would reduce the number of uninsured by less than 2 million, and we could better spend the money to put those people who are uninsured into existing government programs. The tax credit proposal purports to give choice to people, but the choice of an inadequate, expensive plan isn't a choice. Americans who are deemed bad risk—heart condition, history of cancer, high blood pressure, arthritis, asthma, allergies—have very little real choice in the private individual market, and the tax credits aren't going to do them any good.

I know that the Chairman has been critical of the employer-based system. I would like to put into the record the Joint Economic Committee Democratic staff report on the health insurance tax credits. I think my colleagues will find it interesting, and we have copies to pass out. We also have done some research on what health plans are available for a family of four without pre-underwriting in the various communities around the country, which would show that these tax credits aren't going to go very far toward covering people.

It is interesting to note that a famous American politician, a Republican, I might add, has said repeatedly that we should jettison the employer-based health insurance, it is fatally flawed, and replace it, and I think it is interesting. Sixty years ago under a Democratic Administration we went to war, perhaps the greatest war this country ever fought, and we created at that time the employer-based health insurance to protect all the Americans who

were coming in off the farms to pitch in, to help in that war effort, and now under a Republican Administration 60 years later you want to destroy that system as we enter into another war. I think that is a sad commentary. Thank you.

[The information follows:]

JOINT ECONOMIC COMMITTEE

DEMOCRATIC STAFF

SENATOR JACK REED (D–RI) VICE CHAIRMAN

Joint Economic Committee,
Hart Senate Office Building,
Washington, DC 20510.

HEALTH INSURANCE TAX CREDITS:
THE WRONG PRESCRIPTION FOR THE UNINSURED
February 13, 2002

Executive Summary

Despite a strong economy over the last decade, there are still millions of working adults who lack health insurance. High costs and difficulty in gaining access to care are the primary barriers to insurance coverage both for workers and for the unemployed. Many low-income workers are not offered insurance benefits through their employers. For them, the cost of private, non-group insurance plans can be prohibitively expensive. High costs also force some workers to decline employer-sponsored coverage because they cannot afford the employee share of the premiums. The unemployed face similar problems, and for them finding affordable health insurance coverage can be even more difficult.

Providing tax credits for health insurance is one approach that has been proposed as a means of reducing the ranks of the uninsured. The Bush Administration, for example, has proposed a refundable tax credit for uninsured individuals and families. But tax credits cannot fully address the problems of access and affordability for the vast majority of the uninsured in the United States.

The purpose of a tax credit is to lower the cost of health insurance premiums sufficiently to allow more people to buy coverage. Proponents argue that a health insurance tax credit would expand coverage by giving people money—either a fixed percentage of premium costs or a flat dollar amount—to use toward purchasing a plan in the private, non-group market.

To be effective, the credit must be large enough to allow the low-income uninsured to afford coverage and to give private insurers an incentive to provide that coverage. Under current tax credit proposals, however, health insurance would still be out of reach for most low-income Americans. Many very poor families would have to spend more than half of their annual income on health insurance to receive coverage under these plans. Tax credits alone would also do little to improve access to coverage, because providing coverage to people with health risks will not be profitable for insurers unless premiums are very high or better methods of pooling risks are developed. As a result, insurance providers may still turn away some uninsured because of age or health status, even if the applicants can afford to pay somewhat higher-than-normal premiums.

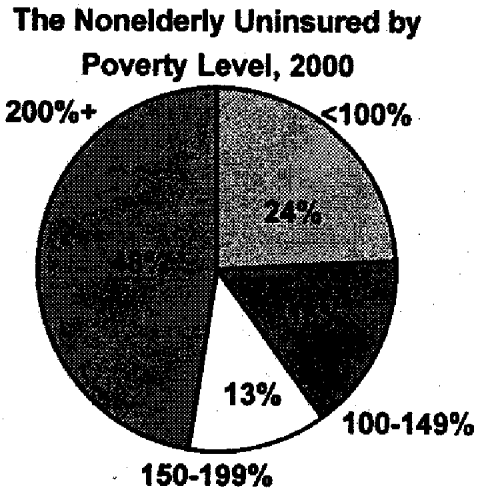
A more effective way to guarantee health coverage for the poor would be to extend coverage through existing public programs such as Medicaid and SCHIP. Most proposals would grant free coverage to the very poor and allow the near poor to buy into public programs at reduced rates. The advantage of these proposals is that they would virtually eliminate the problem of health insurance coverage for the poor, without spending public resources to subsidize those who can already afford and gain access to health insurance. In the longer run, offering tax advantages for health insurance for higher-income employees who are not covered by employer plans may even induce some employers to drop their plans, raising public costs for health insurance even further.

I. Why Do More Than 38 Million Americans Lack Health Insurance?

In 2000, more than 38 million Americans did not have health insurance at any point during the entire year, and many more lacked insurance for at least part of the year. Further, many of those who did have some insurance did not have enough coverage to allow them to pay for all their health care needs. These problems occurred in spite of record levels of employment, the most common source of health

insurance. As the economy slows and unemployment increases, the number of uninsured will continue to rise.

Most of those without insurance are working adults under the age of 65. More than 75 percent of the uninsured—some 30 million Americans—are between the ages of 18 and 64. Most of them are working poor. The overwhelming majority (75.9 percent) worked either full- or part-time during the year, yet more than half of the nonelderly uninsured have household incomes that are less than 200 percent of the Federal poverty level (FPL), which in 2000 was about $17,500 for a family of four.



Source: JEC Democratic Staff analysis of Congressional Research Service and U.S. Census Bureau Data

Barriers to Coverage: Access and Affordability

There are two primary barriers to coverage for the low-income uninsured—access and affordability. The cost of a comprehensive health insurance plan can be a significant share of a low-income family's monthly budget. After paying rent and buying food, many simply cannot afford to pay insurance premiums.

Access to coverage is also a serious problem. Many people are uninsured because they do not meet the eligibility requirements for group plans or for public programs such as Medicaid. Those who have past or present health problems may be unable to find an insurer willing to cover them in a private, non-group plan, and these plans often exclude existing medical problems and are very expensive when they do exist.

The problems of affordability and access plague all three markets for health insurance—employer-sponsored group insurance, public programs, and private non-group plans.

Employer-sponsored group insurance

Most Americans with health insurance are covered by a plan offered by their employer. However, many of the uninsured do not have access to an employer-based plan. The majority (80 percent) of those who are working but uninsured are not of-

fered or are not eligible for an insurance plan at work.[1] Smaller firms, which tend to employ more low-wage workers, are much less likely than large firms or those with a higher proportion of high-wage employees to offer health insurance benefits. Even if an employer offers health benefits, many part-time and temporary employees are not eligible to participate. While employer contributions and tax advantages make employer-sponsored plans generally more affordable than non-group plans, the cost of the employee share of the premiums may still put insurance out of reach for low-income workers. In 2001, workers paid an average monthly premium of $150 for a family health insurance plan.[2] A worker making minimum wage would earn $717 a month before taxes; therefore, such health insurance premiums would cost about 20 percent of the worker's gross monthly earnings.[3]

Public coverage

Medicaid offers an insurance safety net for some very low-income families, but not all. Federal law established a stringent set of eligibility guidelines for the program. Very few adults without children can qualify, regardless of how poor they may be. More than 80 percent of uninsured adults with incomes below 200 percent of poverty do not qualify for Medicaid coverage.[4] Many of these adults are disabled, but even their poor health does not necessarily qualify them for coverage. In most states, non-working individuals with a chronic disability are not eligible for Medicaid unless their incomes are below 74 percent of the poverty line (about $6,8000 for a single adult). A disabled adult being supported by a spouse or parent making the minimum wage, for example, would not qualify for Medicaid. The disabled cannot get Medicare coverage until they have been receiving Social Security disability benefits for 2 years. So while public insurance programs have been very effective in expanding coverage to the elderly and poor children, a large portion of the low-income population remains uninsured.

Private non-group insurance

The only avenue left for people without access to employer-sponsored coverage and who do not qualify for public programs is private, non-group insurance. But securing coverage in the private market is very difficult. Insurers in most states have the right to refuse coverage based on health risk and age. This means that people who have had a heart attack or who suffer from chronic health problems may not be able to find an insurer willing to cover them. One-third of insurance applications from people with mild to severe health problems are rejected.[5] Even those who are accepted may not be able to get insurance that covers their pre-existing health problems.

Even if someone is able to get coverage, the cost of a plan with adequate benefits can be prohibitive. Insurers in most states can charge higher premiums based on a person's age or health status. The high costs put this type of insurance out of reach for many people. In the group market, on the other hand, insurers can pool their risk and keep premiums lower. Low-cost insurance plans do exist, but the benefits are very limited—some do not even cover basic maternity care—and the deductibles can be as high as $5,000 per year.

A Growing and Persistent Problem

As unemployment continues to rise and health care costs increase, the number of uninsured people is expected to grow in 2002. More than 60 percent of Americans get their coverage through an employer-sponsored plan.[6] When people lose their jobs, they are at greater risk of becoming uninsured. One estimate suggests that the number of people without health insurance could increase by 2.4 million this year.[7]

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[1] *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* Bowen Garrett, Len M. Nichols and Emily K. Greenman. The Urban Institute for the W.K. Kellogg Foundation

[2] *Employer Health Benefits 2001 Annual Survey.* The Kasier Family Foundation and Health Research and Educational Trust, September 2001.

[3] Calculations by the Joint Economic Committee Democratic Staff. Assumptions: minimum wage of $5.15 per hour, 35 hour work week, 4.3 work weeks per month and 7.5% social security tax.

[4] "The Health Care Safety Net: Millions of Low-Income People Left Uninsured." Families USA, July 2001.

[5] *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* Karen Pollitz, Richard Sorian and Kathy Thomas. The Henry J. Kaiser Family Foundation, June 2001.

[6] "Current Population Reports: Health Insurance Coverage: 2000," Robert J. Mills, U.S. Census Bureau, September 2001.

[7] "Rising Unemployment and the Uninsured," December 2001, Kaiser Family Foundation. Analysis by Jonathan Gruber suggests that for every percentage point increase in the unemploy-

The Consolidated Budget Reconciliation Act 1985 (COBRA) (see box) allows many people who have insurance coverage through their jobs to continue it after they are laid off. The vast majority of laid-off workers either cannot or choose not to take advantage of this opportunity, however. Over 40 percent of workers and their adult dependents, often those in the lower-income brackets, fail to meet COBRA's eligibility standards. Small firms, for example, are not obligated to offer COBRA coverage to workers. High costs prohibit many of the remaining 50 to 60 percent of unemployed workers from participating. Under COBRA, employees must shoulder the entire burden of the premium costs plus an additional 2 percent administrative fee.

> ***What is COBRA?*** The Consolidated Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer the option of continuing group health insurance coverage if an employee is fired, has his or her hours reduced, retires, dies, or gets divorced or separated. Workers who are fired or have their hours reduced can continue coverage for 18 months, otherwise they can carry it for 36 months. Employers do not pay any share of the premiums. The individual must pay the full cost of the health insurance premium as well as a 2 percent administrative fee.

The increase in the cost of health insurance for the individual losing a job can be substantial because, on average, employers pay almost three-quarters of the cost of the health insurance they provide as a fringe benefit for their employees.[8] Few continue to pay a share of health insurance premiums when workers become unemployed, however. In 2001, the average monthly premium (including both employee and employer shares) for an employer-sponsored plan was $221 for an individual and $588 for a family.[9] This means that average workers with family coverage would see their share of premiums rise from $150 a month when they were employed to $588 a month when they were unemployed and using COBRA. Even those workers who are employed may find health insurance more difficult to get in tough economic times. As the job market gets tighter, employers have less incentive to offer health insurance benefits to lure new employees. They may stop offering insurance or shift a greater share of the premium cost to employees.

II. Can a Health Insurance Tax Credit Help the Uninsured?

Tax credits have been proposed as one option to help reduce the ranks of the uninsured. A health insurance tax credit would give people money—either a fixed percentage of premium costs or a flat dollar amount—to use toward the purchase of a health insurance plan in the private, non-group market. (Some proposals would also allow the credit to be used toward COBRA coverage or the employee share of premiums in an employer-sponsored plan.) Refundable credits would allow any eligible individual to get the credit, even if he or she does not have any income tax liability.

> ***What is a Tax Credit?*** A tax credit is used to reduce an individual's tax liability. The recipient generally must complete an income tax return to get the credit. If the credit is refundable, amounts in excess of a worker's tax liability are paid to the worker. As opposed to a tax deduction, which reduces an individual's taxable income, the value of a tax credit is the same for everyone and does not increase for those in higher tax brackets.

Proponents argue that health insurance tax credits can help expand coverage by giving people the resources to purchase coverage and allowing them the freedom to choose among the options in the private market. However, tax credits are an inefficient and relatively high cost tool to expand health insurance coverage, particularly for low-income people. Tax credits do not address some of the fundamental problems with access and affordability of coverage in the private, non-group market.

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ment rate the number of uninsured people increases by 860,000. This estimate assumes unemployment rises to 6.8%.

[8] *Employer Health Benefits Annual Survey 2001.* In 2001, employers paid 73% on average for a family health insurance plan.

[9] *Employer Health Benefits Annual Survey 2001.*

Affordability of Insurance with Tax Credits

The tax credits proposed to date are too small—relative to the cost of premiums in the private, non-group market—to allow many of the low-income uninsured to buy adequate coverage. Even with the additional funds, insurance premiums can be a significant share of income for poor individuals and families. For some young and healthy individuals who can find inexpensive coverage fairly easily, a tax credit could make coverage more affordable. But premiums for nongroup coverage can be significantly more expensive for older and less healthy people.

Timing of payments is also a crucial part of making insurance affordable. People need the money on a monthly basis to pay their premiums. Tax credits are typically paid out as annual, lump-sum payments.

- **Health insurance premiums can be a significant share of income for poor families, even with the added funds from a tax credit.** Very poor families—even with the benefit of a tax credit—would likely have to spend half or more of their annual income in order to purchase a health insurance plan. According to the Employer Health Benefits Survey 2001, the cost of an employer-provided family plan was about $7,000 in 2001. The Administration's tax credit proposal would give a $1,000 per adult and $500 per child for a maximum of $3,000 for a family. It is important to note that these estimates are based on the cost of premiums for group policies offered through an employer. A non-group plan that included the same type of benefits could be twice as expensive and would consume an even greater share of family income.

Cost of Group Health Insurance As a Percentage of Family Income
Credit = $1,000 per adult, $500 per child

With a $2,000 tax credit one adult, two children		**With a $3,000 tax credit** two adults, two children	
Family Income (2001$)	**Percentage of Income**	**Family Income** (2001$)	**Percentage of Income**
$7,100 approximately 50% of poverty	70%	**$9,000** approximately 50% of poverty	45%
$14,300 approximately at poverty level	35%	**$18,000** approximately at poverty level	22%
$21,400 approximately 150% of poverty	23%	**$27,000** approximately 150% of poverty	15%

Source: JEC Democratic Staff calculations.

A tax credit would do little toward making insurance affordable for these individuals and families. An alternative approach that would do more to make insurance affordable would be to cap the cost of premiums paid by poor people. For example, federal law caps the cost of premiums for low-income families enrolled in the State Children's Health Insurance Program (SCHIP) to 5 percent of family income. This approach would help to target federal subsidies for health insurance toward those who need them most.

- **Premiums in the non-group market are generally more expensive than comparable employer-provided or public insurance plans.** Insurers can and do increase the cost of a plan based on a person's health status. In one study, almost half of all accepted applications had premiums above the standard rate because of a pre-existing health problem. The added costs are not just for people in very poor health. Common afflictions such as hay fever and sports-related knee injuries can also raise the price of insurance in the non-group market.[10] Premiums also increase with age. In some cases, a healthy 55 year-old can be charged twice as much as a 25 year-old for the same type of coverage.[11]

[10] Pollitz et al.

[11] *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured.* Families USA Foundation, September 2001.

Recent Tax Credit Proposals

Examples of recent health insurance tax credit proposals include:

In its FY 2003 budget, the Bush Administration has proposed a refundable income tax credit for the purchase of health insurance in the private, nongroup market for people under age 65.

- The maximum value of the credit would be $1,000 per individual, $500 per child, maximum credit would be $3,000 for a family.
- The credit would be targeted to low-income people. It would begin to phase out for individuals without dependents with an adjusted gross income (AGI) of $15,000 and for families with two or more children and an AGI of $25,000.
- Starting in July 2003, recipients could receive the credits in advance. Eligibility for the credit would be based on the prior year's income.
- The IRS would not seek to reconcile advance payments with actual earned income at the end of the year.
- The credit could not be used to pay premiums for employer sponsored or public health insurance plans.
- Starting in 2004, states could allow certain individuals to use the credit to purchase private insurance through a state-sponsored purchasing pool.

The economic stimulus package passed by the House of Representatives in December 2001 included a temporary, refundable health insurance tax credit for unemployed workers that would pay up to 60 percent of health insurance premiums for a plan under COBRA or one purchased in the private, nongroup market.

- Only workers who were laid off after March 15, 2001 and eligible for unemployment compensation or are certified by a state as eligible for benefits but are beyond their benefit year or have exhausted their maximum benefit levels would be eligible for the credit.
- There is no income eligibility requirement.
- The credit would only be available for 12 months.
- Eligible individuals would file for a health insurance credit eligibility certificate as part of the process for applying for unemployment compensation. Individuals would pay 40 percent of their premium to their insurance company, and the Federal Government would directly reimburse the provider for the balance.

- **People need the money on a monthly basis.** Insurance payments are due every month, but most tax credits are single, lump-sum payments. Without a monthly flow of funds, health insurance will not be affordable for many low-income households. To best help low-income households that face tight monthly cash constraints, financial assistance for health insurance needs to be spread throughout the year. The current tax system is not structured to meet this demand. Changes would have to be made—new procedures, new tax laws, new tax forms—to an already complicated tax code in order to get the health insurance tax credit funds out on a monthly basis.
- **The availability of low-cost plans is limited and the benefits are poor.** Given the high cost of comprehensive insurance plans, one option for the uninsured would be to purchase a plan equal to the size of the tax credit. While there are some low-cost insurance plans ($1,000 or less annual premium for an individual) available in the private, non-group market, recent surveys suggest that these plans are not abundant, they are not always available nationwide and they are generally poor in quality of coverage.

  A study by Families USA found that six of twenty-five states surveyed did not have any $1,000 plans available for a healthy 25 year-old woman. Eighteen states did not have $1,000 plans for a healthy 55 year-old woman. Because insurance coverage for families and people in less-than-good health is more expensive, it is likely that people in those circumstances will have even fewer options. And even when low-cost insurance plans are available, there is no guarantee that insurance providers will approve specific applicants for coverage.

  The low-cost plans that do exist have limited coverage and are of little use to the low-income uninsured. Almost no existing insurance plans with annual pre-

miums of $1,000 or less cover maternity care and many do not cover emergency care, mental health services or prescription drugs. The deductibles are very high—often ranging from $500 to $15,000 for a family plan. After the deductible is met, many plans also have a coinsurance fee that would require the insured to pay a certain percentage of the costs of any medical services they used. Some argue that deductibles, co-insurance fees and copayments help limit the "moral hazard" problem in health insurance by creating an incentive for people to limit unnecessary treatment. However, the extremely high cost of some deductibles and coinsurance rates can put health care completely out of reach for many low-income people.

Supporters of tax credits suggest that families could set aside funds in tax advantaged flexible savings accounts (FSAs) to cover the cost of deductibles. While this may be a good option for some people with access to an FSA and sufficient disposable income, it would not help most of the low-income uninsured. First, workers can only access an FSA through their employer. Part-time workers and workers in small firms are less likely to have or be eligible for an employer-sponsored FSA. Second, workers must have sufficient disposable income to contribute to the account. Low-income workers on tight budgets would be less likely to be able to afford regular contributions. They would also get less of a tax break on their savings than higher-income workers. Even if FSAs are modified to allow workers to rollover contributions from year to year (currently, a worker must forfeit any unused funds at the end of the year), it could still take a long time for a low-income worker to accumulate sufficient funds to make a $5,000 or higher deductible affordable.

Insurance companies have little incentive to offer low-cost insurance plans because they are not likely to be very profitable. The market for these plans is limited because their coverage is poor and most people without known health problems would get little benefit from them, so insurers do not have a large pool over which to spread their risks. If a significant number of people with low-cost plans incur high medical costs, the insurers could lose money.

Access to Insurance with Tax Credits

Money is not the only barrier to coverage for the uninsured. There is no guarantee of coverage in the private, non-group insurance market. Insurers in most states have the right to deny or limit coverage based on age and health condition.[12] Even with funds from a tax credit, some of the uninsured may simply not be able to find a private insurance firm willing to offer them adequate coverage. A tax credit does nothing to address this problem.

The problem of access also extends to the tax credit itself. If eligibility for the credit is based on prior-year earnings, as has been suggested, people in need of health insurance assistance this year may not qualify for the credit.

- **More than a third of applications for non-group coverage may be denied due to mild or serious health conditions, according to a recent study.**[13] Further, more than 60 percent of the accepted applications imposed some kind of restriction based on pre-existing health conditions. Even minor problems can cause difficulties. In one case, some insurance carriers rejected a woman with hay fever and more than 80 percent of her acceptances came with coverage exclusions. A coverage exclusion means that the insurance plan will not cover costs relating to a specific illness or a part of the body. So while money is an important part of the equation for expanding health insurance coverage, it will not help people who are effectively shut out of the market as a result of their age or health status.

[12] Fifteen states require insurers to guarantee coverage for all participants in non-group plans. However, half of these states only require insurers to offer a basic plan. Even with a guarantee of coverage, insurers in almost all states can charge higher premiums based on health status and age.

[13] Pollitz et al.

Crowding Out If the government offers a tax credit for health insurance, there is a risk that some people will drop their employer-sponsored coverage in order to collect the money and purchase a private plan. This is called *crowding out*. This raises the possibility that, over time, employers will be less likely to offer insurance so that their employees can take advantage of the tax credit. Without the option of affordable, group insurance that mandates coverage, more people may become uninsured.

In initial descriptions of its tax credit policy, the Administration suggests that the uninsured could get access to insurance through state-sponsored insurance purchasing and high-risk pools. However, in their current form, high-risk pools would not be much better than the private market. Not all states have a high-risk pool, and those that do have them usually limit the number of enrollees. Only about 110,000 people nationwide are insured through these pools. While people may be able to get an offer of coverage, the premiums are often very high—an average of $3,083 for an individual plan in 1999—and the deductibles and coinsurance rates are also high. In addition, many pools have a six to twelve month waiting period before an applicant can get coverage.[14]

- **People who need financial assistance the most may not be able to access the tax credit.** Most recent tax credit proposals have addressed the problem of eligibility for very low-income individuals by making the credits refundable—allowing people to get the credit even if they have no tax liability from which to deduct it. Most tax credits can only be used to offset taxes owed, but a refundable credit can be paid directly to people even if they do not have taxable incomes. However, even refundable credits are not generally available until tax returns are filed, which may be a year or more after a worker has become uninsured. This would do little to help those who need health care coverage now.

  Some tax credit proposals would deal with this problem by paying insurance subsidies to those with low incomes as soon as they become unemployed or lose insurance, without requiring reconciliation at the end of the year. This means that people could get the credit without having to go back at the end of the year and verify that their incomes for the year as a whole remained below the eligibility guidelines. Having to do so would be a major administrative headache and could expose some workers to large, unexpected tax liabilities. But such a system has great potential to be abused if no income verification is ever required.

  To allow the credit to be pre-paid—without requiring those who turn out to be ineligible to pay it back—proposals generally base eligibility on the prior year's earnings. This means that people who lose their job or suffer a significant financial setback this year would likely not be able to claim the credit if they had good incomes last year. At the same time, those who have good incomes now but did not last year could qualify for the credit based on last year's tax return.

III. Implementation Problems with a Health Insurance Tax Credit

There are inherent problems in using the tax system to get money to the people who need it the most, when they need it the most. The tax system is based on an annual accounting of income and annual payments of refunds and credits. But an individual's income and expenses, particularly for low-income households, can vary greatly on a monthly basis. In order for a health insurance tax credit to be effective, people need to get the money every month to pay their premiums. Making a health insurance tax credit "advanceable"—delivering subsidies on a monthly basis—poses serious hurdles to effective implementation.

Making the Tax Credit Advanceable

Current tax credit proposals do not fully address all aspects of the process they would use to advance money on a monthly basis. Most tax credit proposals acknowledge the need to make the credit advanceable so that people will have the money on a monthly basis. However, there is not an existing process by which to do this and most proposals offer only a limited description of how they will implement their idea. For example, the Bush Administration proposes that the credit would be paid directly to health insurance providers. Individuals would pay their monthly share of the premium and, using a tax credit identification number, providers would be directly reimbursed by the Treasury Department.

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[14] Achman and Chollett.

Implementation Questions

What process would be used to determine income?

As noted above, there are problems in using the prior year's income to determine eligibility for a tax credit because some people who need the money now may not qualify if they had good earnings last year. If the income tax return is used to determine income eligibility for the tax credit, it would create two problems. First, people who were not required to file an income tax return last year, but otherwise would be eligible for the tax credit, would not be able to get it. Second, people would need to apply for the tax credit throughout the year—not just in April when they file their return.

What process would be used to distribute checks on a monthly basis?

If a tax credit were to be paid directly to the insurance provider, it raises the question of how the government would determine what constitutes an eligible provider. In order to guard against fraud, a process would have to be developed to make sure that insurance providers are legitimate. This could certainly delay the process of implementation.

What incentive would health insurance providers have to participate?

It is unclear whether health insurance providers would have sufficient incentive to participate. While they would get new business under this scenario, they would have to weigh that benefit against the costs of devoting time and resources to accounting for a new stream of funds. If the government does not issue the monthly premium checks in a timely manner, the insurance company could be forced to carry the cost of unpaid premiums. In addition, insurers would have to be held harmless for any fraudulent use of health insurance tax numbers by individuals.

Advancing the Tax Credit through Payroll Deductions

Another option for getting the money into people's hands on a monthly basis is to lower the withholding in their paychecks. This would require the cooperation of employers. Almost all of the people who would be claiming this credit would be working in firms that did not offer health insurance. It is unlikely that these employers would want to take on the added burden of paperwork and adjusting withholding. Of course, individuals who do not work would not be able to claim the credit with this method.

The Earned Income Tax Credit (EITC) offers an example. Data show that almost all recipients opt to take the credit as a lump-sum payment as part of their tax return. As few as 1 percent of recipients opt to submit the necessary paperwork to their employer in order to receive the credit throughout the year in their paycheck. Economic theory would suggest that low income individuals on tight budgets would prefer to receive the money over the course of the year to help meet basic expenses. While there is no evidence about why most EITC recipients opt for the lump sum, it raises the possibility that the added paperwork burden and the involvement of employers may discourage some people.

Access to State-Sponsored Pools

As noted earlier, the Administration has recommended state-sponsored purchasing and high-risk pools as one avenue for the uninsured to get access to coverage. This raises some implementation questions:

How will the Federal government encourage the formation of state-sponsored pools?

Only 29 states currently have high-risk insurance pools and many of these limit the number of people who can join. According to a recent report by The Commonwealth Fund, all of the existing high-risk pools operate at a financial loss. While some limited funds are contributed by insurance companies, state budgets are left to make up the bulk of the shortfall. The initial descriptions of the Administration's tax credit proposal do not include any funding or reimbursements to states to encourage them to establish or expand a state-purchasing pool. As states face tighter budget constraints, many states will not have the necessary resources to cover the pools.

How will the government pool risk?

Uninsured individuals will likely turn to state-sponsored purchasing pools after they have been rejected by insurers in the private market. This means that the vast majority of people in these pools will have past or present health problems that make them a poor risk in the eyes of the insurance pro-

vider. The insurance coverage options available to such a high-risk pool will be limited and carry high premiums.

IV. Conclusion

Despite dramatic increases in wealth and prosperity during the nineties, the lack of health insurance—particularly among low-income individuals—remains a persistent problem. While health insurance tax credits may help some healthy people with good incomes to buy coverage, millions of Americans will not be helped by this approach.

Tax credits do little to address the fundamental reasons why so many low-income people are not able to get adequate health insurance in this country. The size of proposed tax credits would not make health insurance more affordable for many of the uninsured. Premiums for adequate health insurance would consume a significant share of income for poor households—even with the boost from a tax credit. Low-cost insurance plans are not widely available and their benefits are quite limited. And tax credits do nothing to address the serious problem of access to insurance coverage. Even with the necessary funds, many of the uninsured could be turned away from insurance providers because of their age or health status.

Expanding public insurance programs avoids some of the inherent problems with tax credits. Most current proposals would grant coverage free to the very poor and allow the near poor to buy into public programs at reduced rates. Expanding a public program to everyone below a certain income level, regardless of age and health status, would have a dramatic effect on the ability of the low-income uninsured to access coverage. The clear advantage of these proposals is that they would virtually eliminate the problem of health insurance coverage for the very poor.

In order to solve the persistent problem of the uninsured, the nation will need to make a significant investment. Over the long-term, the cost of having millions of people without health insurance and thus without access to basic care will put pressure on public health services and reduce earnings among people who can least afford it.

For additional information, please contact JEC economist Kathleen FitzGerald at 202–226–4065 or Kathleen__FitzGerlad@jec1.house.gov.

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Chairman THOMAS. The Chairman of the Health Subcommittee wishes to intervene.

Mrs. JOHNSON OF CONNECTICUT. I would just like the record to note that Members of both parties for many, many years in this body have looked to subsidizing premiums for people who had to pay for their own health insurance as the way to close the gap and create a system that provided affordable insurance to all Americans. It is not a new idea.

What has changed is that we have figured out how to deliver it promptly, how to deliver it to everyone, and how to provide a subsidy that really is powerful in the market. And to all those Democrats that have cosponsored legislation, introduced tax credit legislation, I just want to say, Mr. Stark, that I don't think that you speak for all in your party when you say that tax credits are not an effective means to reach the uninsured.

So it is a longstanding issue with a lot of Democrat support, and I am pleased that we are moving forward in this hearing on a very powerful approach to providing health security to the unemployed, as well as some level of financial security which our unemployment compensation system is structured to provide. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentlewoman.

Without objection, the Chair would place in the record an article from The Washington Post, June 18, 1999, the co-authors are Dick Armey and Pete Stark, about the positive aspects of a tax credit for the uninsured.

[The article follows:]

Medical Coverage for All

The ultimate congressional odd couple weighs in on tax credits for the uninsured.

The Washington Post
June 18, 1999
By Dick Armey and Pete Stark

We may be the ultimate congressional odd couple. We seldom agree on anything. But on this we do agree: Congress should act now to help the 43 million Americans who have no health insurance.

The ranks of the uninsured are growing by 100,000 a month. And this is happening during a time of strong economic growth, despite continuing congressional attempts to expand coverage. Imagine what will happen come the next economic downturn.

For individuals, being uninsured is a problem because too often it means health care forgone, small warning signs ignored and minor illnesses allowed to become costly crises. It's a problem for families because unpaid medical bills are a leading cause of personal bankruptcy. And it's a problem for the nation because uncompensated care is an unfair burden on doctors, hospitals and taxpayers.

Why is the problem growing? Because Americans are increasingly unable to get coverage through their jobs. With health premiums going up, employers are bearing a smaller share of those premiums, and the work force is becoming increasingly mobile and part-time. More and more people find themselves working in places where coverage is either unavailable, unaffordable or undesirable ("one crummy HMO"). And when these workers try to buy insurance outside their jobs, they lose a generous tax break, making coverage that much less affordable.

Indeed, today's tax code discriminates against not only insurance purchased outside the workplace but also lower-paid, part-time and small-business workers. The highly paid CEO gets a more lavish health-care tax break than the waitress earning the minimum wage.

These problems cry out for remedy. And happily, a bipartisan remedy is available. We think Congress should create a new refundable tax credit to enable all Americans to buy decent health coverage.

Properly designed, such a credit could bring about near-universal coverage without new mandates or bureaucracy. It would eliminate barriers the uninsured face in today's system, enabling them to shop for basic coverage that suits their individual needs and is portable from job to job.

To be successful, the credit would need to be sufficiently generous to buy a decent policy; available to those who owe no tax liability; and, to prevent fraud, paid directly to insurers or other entities, not to individuals.

Would the existence of such a credit prompt some employers and employees to drop workplace coverage? Unavoidably. But job-based coverage is already eroding. And the erosion can be minimized by making the credit less attractive than most company plans.

To be sure, we don't want to end workplace coverage. We do want to permit a gradual transition to a world in which individuals are free to obtain the kind of insurance they want, regardless of where it's purchased.

What amount is "sufficiently generous"? That's open to debate. But we note that $3,600 per family is roughly the amount the federal government spends on its own employees' families.

Obviously this proposal would produce a revenue loss of tens of billions a year, risking a return to deficits. So how do we "pay" for it? Well, a portion of the surplus could be used. And we note that reducing the numbers of the uninsured would free billions in current federal cross-subsidy programs.

Admittedly, a tax credit can't help people who are too sick to insure at any price. Although we differ, fairly strongly, about the best way to help such people, we agree a reasonable way can be found to do so, and we'll keep looking for it. (Rep. Stark would prefer to get insurers to take all customers at a common price, regardless of health status. Rep. Armey would set up "high-risk pools" to subsidize sick people's coverage in the 22 states that haven't already done so.)

Too often, when Congress turns to health issues, it ends up applying legislative Band-Aids. It's time to address underlying causes. The biggest health problem facing the country is the uninsured. The Tax Code can be used to help them. We urge a bipartisan consensus to do so.

Rep. Dick Armey (R-Tex.) is the House Majority Leader. Rep. Pete Stark (D-Calif.) is the senior Democrat on the House Ways and Means health subcommittee.

Mr. STARK. Would the gentleman yield at that point?

Chairman THOMAS. Certainly.

Mr. STARK. Because he is quite correct, I worked for a long time with Majority Leader Armey to see if we could do it, and we came to the conclusion that while a minimum of a $3,600 tax credit was necessary, first of all it had to be universal, it had to replace the entire health care system, and it had to have regulation over the insurance industry. Mr. Armey felt that he couldn't get the Republicans to agree to that, we would have to have community rating and no underwriting, that it wouldn't work without regulating the insurance companies, and we agreed at that point that it was a good idea but politically impractical without the second half, which would have been our controlling the insurance industry.

Chairman THOMAS. I will tell the gentleman that in his opening remarks he did indicate that there were individuals who thought the employer-based system was flawed. Apparently he is among them, and if he wishes to work with the Chair on those additions which would make an adequate tax credit insurance structure, the Chair is more than willing to work with the gentleman. Although I certainly couldn't replace Dick Armey in the team of Dick Armey and Pete Stark, I would be willing to work on that.

And with that, it is a pleasure to have in front of us again the Honorable Mark B. McClellan, Member of the Council of Economic Advisers (CEA) in the Bush Administration, and the Honorable Mark Weinberger, who is the Assistant Secretary for Tax Policy at the U.S. Department of the Treasury. Your written statements will be made a part of the record, and if you could summarize briefly, we would appreciate that, so that we could move to the questions focused in part upon the President's proposal in his budget. I assume, Mr. Weinberger, you will begin?

STATEMENT OF THE HON. MARK WEINBERGER, ASSISTANT SECRETARY FOR TAX POLICY, U.S. DEPARTMENT OF THE TREASURY

Mr. WEINBERGER. Yes, Mr. Chairman. Thank you.

Mr. Chairman, Mr. Rangel, distinguished Members of the Committee, I appreciate the opportunity to discuss with you today the President's proposal for tax credits for the purchase of health insurance. The Administration looks forward to working together with Congress to address the pressing need to expand access to health insurance for uninsured Americans.

Almost 40 million Americans are reported to go without health insurance coverage for an entire year, and as many as 20 million more are without health insurance coverage during some part of the year. The scope and persistence of this issue highlights the importance of our making progress this year.

Tax credits to expand access to health insurance are a common element of proposals from both Republicans and Democrats. Many of the Members of this Committee have supported such proposals and sponsored such legislation in prior sessions of Congress. We just seek to bridge partisan divides and seek common ground on this key issue which enjoys such bipartisan support and is important to uninsured Americans.

As we move forward together on the issue, I hope we can make some commitments to each other. When we see a weakness in a particular element of a proposal, let's make a resolution to try and identify a fix. When we question the motives of alternative approaches, let's have the resolution to focus on our shared objectives of better and affordable health insurance for all. When there are heartfelt differences of opinion, let's have the resolution to listen and not just hear. And when we recognize good ideas in each other's perspective, let's have the courage to learn from them, adopt and innovate.

Finally, there are many tradeoffs in developing a comprehensive solution. A policy that excels along one dimension may do poorly along others, and we have to balance these competing dimensions. There is a need for flexible and innovative solutions to this problem. The reality is that there is no single approach that will resolve the entire issue.

The uninsured population is not made up of just the poor or the unemployed. In 1999, 81 percent of the uninsured population were in families with at least one full-time worker. While more than one-third of the uninsured had incomes below the poverty line, approximately 29 percent had incomes between 100 and 200 percent of poverty. Nearly three-quarters of the uninsured below 200 percent of poverty are adults, many who do not live in-households with children.

Given the need for a broad approach to this problem, the President supports both an immediate temporary health insurance credit for displaced workers, as contained in the economic security package passed by this body, and a permanent new health insurance tax credit to expand health insurance coverage that is not dependent upon employment status. For brevity, I will describe the displaced worker credit and my colleague, Mr. McClellan, will discuss the permanent health insurance credit.

The health credit for displaced workers is a refundable, advanceable tax credit that can be claimed by unemployed workers for up to 12 months. The credit can be used to offset 60 percent of the cost of health insurance premium for unemployed workers and their families. The credit can be applied to the purchase of the Consolidated Budget Reconciliation Act of 1985 (COBRA) and other types of qualified non-employer health insurance. Eligible unemployed workers include those who receive unemployment insurance benefits and those who would be eligible for those benefits, except that the rights to benefits were exhausted or the period in which the benefits were payable ended.

The design of the health credit reflects the President's goal of providing targeted, quick assistance to Americans who have lost their jobs during this recession. Because it builds on existing infra-

structure to assist displaced workers, it can be fully implemented in a matter of months.

In particular, State work force agencies will certify eligibility for the credit when they certify the displaced worker is eligible for unemployment insurance benefits. That certification will be presented to the insurance company along with the remainder of the premium. The insurer will be reimbursed by the U.S. Department of the Treasury for the amount of advance credit it provides.

We believe that the displaced worker credit offers a number of advantages over competing proposals that have been advanced that would have been COBRA-only policies or expansion of Medicaid assistance. A COBRA-only credit would provide no benefit to 40 to 50 percent of displaced workers.

A COBRA credit would impose a costly new mandate that employers would be required to implement immediately. Further, a COBRA credit is poorly targeted to workers who lose their jobs because of the economic downturn. About 60 percent of those eligible for a COBRA credit are workers who voluntarily leave their job, not displaced workers.

Some have advocated forcing workers not eligible for the COBRA credit into a State Medicaid plan. There are many troubling aspects of that temporary relief. This would require these workers to drop their current insurance coverage and possibly change health insurance providers if they do not participate in Medicaid.

Extending Medicaid to cover these displaced workers would require State legislation, and would necessitate delays before State legislatures were even in session to be able to provide this so-called immediate relief. The cost to States of such expansions could be ill afforded by many States at the present time, and would take away resources from their ability to fund expansions for low-income children and families who also need assistance.

So, in short, that is the description of the displaced worker credit, and I turn to Mr. McClellan to talk about the permanent health insurance credit.

STATEMENT OF THE HON. MARK MCCLELLAN, MEMBER, COUNCIL OF ECONOMIC ADVISERS

Mr. MCCLELLAN. Mr. Chairman, Mr. Rangel, and distinguished Members of the Committee, I also want to thank you for the opportunity to discuss with you today the President's proposals for health credits as one element of an effective policy response to address the urgent problem of the uninsured in the United States. The second credit we will highlight is the permanent health insurance credit contained in the President's budget proposal.

This proposal would create a refundable, advanceable tax credit for the cost of health insurance purchased by individuals under age 65. Individuals participating in employer-provided health plans or generally in a public plan would not be eligible for the credit. Eligible health insurance plans would be required to meet some minimum coverage standards, including coverage for high medical expenses.

This credit is designed with a number of attractive features in mind, reflecting our efforts to learn from and incorporate the best ideas of previous proposals as well as critiques of those proposals.

Our goal is to maximize the impact of the credit on the uninsured, while minimizing any undesirable effects on currently covered workers. This includes significant modifications of the credit that the President proposed in his budget last year.

First, the credit amount varies with family size, mirroring the relationship of actual health insurance premiums. The maximum credit would be $1,000 per adult and $500 per child up to two children in a family. For example, a policy covering two adults and two or more children would be eligible for the maximum credit of $3,000.

Second, the credit is targeted to lower—and middle-income individuals and families who are least likely to have employer-based health insurance, resulting in an efficient use of the subsidy to expand coverage. The credit phases out with incomes. It is further limited by a cap on the amount of the premium eligible for the subsidy. The maximum subsidy percentage of 90 percent would apply for low-income taxpayers and would be phased down at higher incomes.

Third, the credit is refundable, so even those without any income tax liability can receive the subsidy.

Fourth, the credit is available in advance at the time that the individual purchases health insurance, before they file their tax return. Eligibility for the advance credit would be based on the person's prior year's tax return. Individuals would reduce their premium payment by the amount of the credit, and the health insurer would be reimbursed by the U.S. Department of the Treasury for the amount of the advance credit. Alternatively, instead of an advance credit, individuals could claim a credit as part of the normal tax filing process based on their current year income. The availability of the advance credit will make the credit much more attractive for persons who want to use the assistance when they are actually purchasing their insurance, not later, making it even more effective in expanding health insurance coverage.

Fifth, while the credit could be used for the purchase of health insurance in the nongroup market, qualifying health insurance could also be purchased through private purchasing groups, State-sponsored insurance purchasing pools, and State high risk pools. These groups can promote risk pooling and provide economies of scale, resulting in additional opportunities for individuals to get affordable coverage. States can also provide additional subsidies for lower income participants.

There is considerable new evidence that this proposal could have a rapid and substantial impact on the uninsured. The Council of Economic Advisers has just released a new analysis of the credit, which I would request to be read into the record.

[The information follows:]

Council of Economic Advisers
February 13, 2002

HEALTH INSURANCE CREDITS

SUMMARY

The President's proposal to introduce tax credits for the purchase of health insurance will enable millions of Americans to purchase private health insurance, improving the functioning of private markets, empowering patients to make informed decisions, and increasing utilization of high quality health care.

This proposal is part of a broader vision for promoting access to innovative, high-quality patient-centered health care for all Americans, by encouraging effective patient choice among competing health care coverage options. This vision is discussed in more detail in the *2002 Economic Report of the President.*

Program Description

- The health insurance credit is available to anyone under 65 without employer-sponsored or public insurance. Individuals would be eligible for a tax credit of up to $1,000, and families purchasing a family policy would be eligible for a tax credit of up to $3,000.
- The health insurance credit is "refundable," so that even those without tax liability can take advantage of it. It is "advanceable," so that people will have immediate access to the credit when they want to buy insurance, rather than having to wait until they file tax returns. The advance credit is based on income in the previous year, so people will not have to worry about having to return the credit if their incomes change over the course of the year.
- The maximum subsidy rate would both phase out at higher incomes, with a maximum subsidy rate of 90 percent. The phase-out, described below, would begin at $15,000 for single filers and $25,000 for others.

Policy Effects of the Health Insurance Credit

- *A significant number of currently uninsured people will take advantage of the tax credit.*

  Research suggests that the tax credit will allow **6 million** or more Americans who would otherwise be uninsured during a year to gain coverage. The credit covers a substantial portion of the premiums most people would face in the private individual insurance market, thus increasing participation in and enhancing the efficiency of the individual market for health insurance.

  Anyone without employer or public insurance, including people who would be ineligible for assistance through expansions of Medicaid or the State Children's Health Insurance Program and dislocated workers who do not have COBRA coverage available to them, would be able to take advantage of this program.

- *The incentives created by the credit could improve the functioning of the individual private market and enable people to make informed decisions about their care.*

  Currently individual health insurance policies are expensive in part because many healthy people do not participate in the individual market. The health insurance credit encourages participation, especially among healthier individuals, and thus improves the "pooling" of health risks. Because people would have to pay at least some portion of their premiums, they would have an incentive to be well-informed and to seek out high value, high quality, informed care.

- *The credit makes the system of subsidies more equitable.*

  Employer-sponsored insurance (ESI) is already subsidized through the Tax Code, because employer contributions are untaxed, with the biggest tax benefits going to those with high earnings. People with the same income are also treated differently, based on the source of their insurance. The health insurance credit would make the system more equitable and more progressive, since it would be largest for those with lower incomes and would be available to those who do not receive subsidies through the current system.

- *The health insurance credit will complement the employer-sponsored group markets.*

  Because the health insurance credit is less generous than the tax subsidy on a typical employer plan for all but the lowest-income workers, the proposed

credit would not substitute for the employer-sponsored group market. Any employee eligible for ESI who opted for the new credit would have to pay taxes on any additional wages earned in lieu of health insurance coverage, and would only be entitled to a capped credit. Employer decisions about offering health insurance, and the generosity of the insurance, depend on the value of the tax subsidy to average or typical employees and not just low-income employees. Most employers offering coverage would continue to do so, and low-income workers in these firms would continue to benefit from these generous contributions. Thus, the majority of those taking up the new health credit would be people who were either previously uninsured or previously covered in the non-employer market.

- *The health insurance credit does not distort labor markets.*

  The credit is available to anyone under 65 without employer-sponsored (or public) insurance, so it does not provide a disincentive for employment at the individual or firm level. Because the advance credit is based on the prior year's income, people can take new jobs without fear of having to repay it at the end of the year.

THE UNINSURED AND HEALTH INSURANCE MARKETS

The goal of the health insurance credit is to increase participation in and improve the functioning of health insurance markets. To see the value of this improvement, it is important to understand the composition of the uninsured population and how those markets function.

The Uninsured

In 2000, approximately 39 million Americans, or 14 percent of the population, reported that they were uninsured for the entire year.[1] They may go without effective health care, or may rely on inefficient care at emergency rooms and clinics.[2] Expensive expansions of government run health care programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) in the 1980s and 1990s did little to change the number of uninsured.

The uninsured population is not made up of just the poor or the unemployed. Over 80 percent of the uninsured population in 1999 were in families with at least one worker. Furthermore, while 36.4 percent of the uninsured had incomes below the poverty line, a large fraction, 28.7 percent, had incomes between 100 and 200 percent of poverty.[3] As shown in Figure 1, nearly three-quarters of the uninsured below 200 percent of poverty are adults, most of whom do not live in-households with children. These childless adults would benefit from the health insurance credit, but would not be assisted by proposals to expand the SCHIP program to include parents. That said, many of the children who are currently uninsured are also eligible for Medicaid or SCHIP. Coupled with continuing outreach efforts to increase Medicaid and SCHIP enrollment, the availability of the credit provides another opportunity for low-income families to get coverage.

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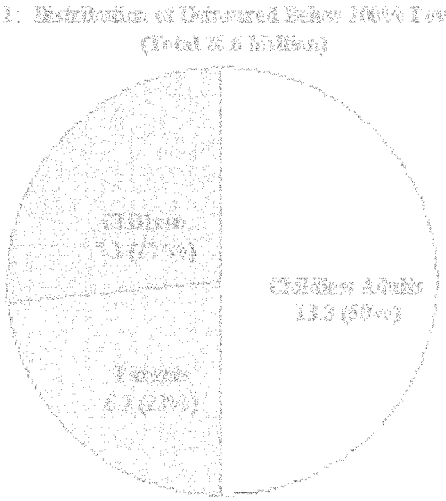
[1] Estimates of the number of uninsured vary depending on the survey question and the length of time uninsured. This estimate is based on the March 2001 Current Population Survey. Data from other surveys such as the Survey of Income and Program Participation suggest that 55 to 60 million were uninsured for part of a year or more.

[2] Kaiser Family Foundation, *Uninsured in America: A Chartbook* (2000); Urban Institute, *Health Insurance Access* and Use: United States, (July 2000).

[3] Kaiser Family Foundation, *Uninsured in America: A Chartbook* (2000). Note that the Census Bureau does not report coverage for families with income between 100 and 200 percent of the Federal poverty line.



Insurance coverage differs significantly by race and ethnicity. In 2000, 32 percent of Hispanics were uninsured, compared to 20 percent of blacks and 19 percent of Asians. In contrast, just 10 percent of whites are uninsured.[4] Insurance coverage also differs across types of employment, with employer-sponsored insurance less likely to be available to part-time, seasonal, and short-term workers.

The benefits of increasing participation in health insurance markets extend beyond those realized by the individuals themselves. First, even those without insurance receive publicly subsidized basic health care through emergency rooms—a very expensive way to provide care. Second, access to health care is important to control the spread of disease through immunizations or through early diagnosis and treatment. Third, greater participation in insurance markets allows broader pooling of health risks—the markets themselves work better.

Insurance Markets

One important goal of health insurance is to reduce the risk to individuals of high medical expenses, trading the certainty of a known premium for the uncertainty of very unpredictable health care costs. An important element of insurance is thus the "pooling" of risk—people sign up for insurance before they know how much they will spend on health care, and then the premiums of those who have low expenses help subsidize spending on those with high expenses.

Several things can interfere with the smooth functioning of this important insurance market. One is lack of choice and competition. Health insurance plans have little incentive to adapt to changes in medical care in order to compete for enrollees if the enrollees have no other options. Insurance markets with little or no competition are thus unlikely to keep up with innovations in health care, and without market discipline plans may encourage excessive care and inappropriate treatments. A second problem is "adverse selection": If individuals know their likely health insurance expenditures ahead of time, they can sign up for more generous insurance when they know their expenditures will be high, undermining the pooling of risk that is the key to insurance. Given a choice among plans, the healthiest people (with the lowest expected costs) can save money by pooling together in the least generous plan, or dropping insurance altogether, making the cost of the more generous plans rise as the expected costs increase.[5] Just as individuals with higher expenses want

[4] Census Bureau, *Health Insurance Coverage,* 1999.

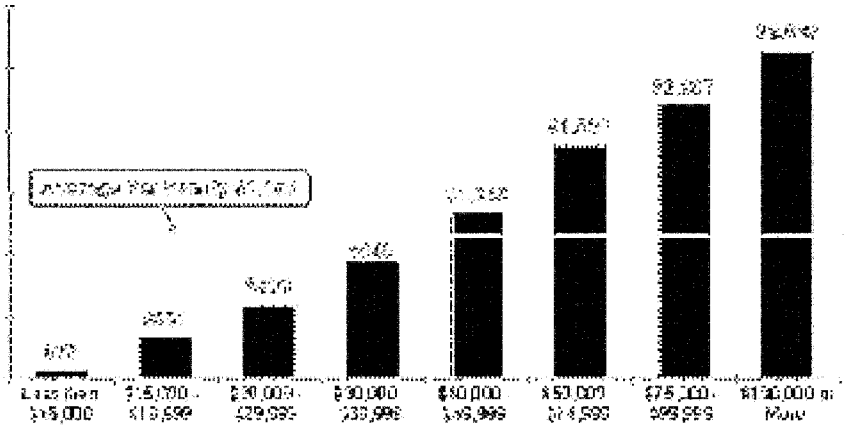
[5] This can again induce the healthiest remaining in the more generous plan to leave that plan. In extreme cases, this drives the most generous plans or those with the sickest members out of the market altogether.

more insurance, insurance companies want customers with lower expenses, and may cater their plans to appeal to those with low risk.

Both of these incentive problems can lead to premiums that are higher than they need to be, lower value care because efficient services are not offered, and increases in uninsurance because people conclude that the coverage is simply not worth the cost. The result of non-optimal coverage is inefficient health care use, with worse health outcomes and avoidable costs due to disease complications that could have been prevented with better coverage. The health insurance credit can improve the functioning of health insurance markets by addressing these problems.

The vast majority of private health insurance in the U.S. is purchased through employers. An important reason is that these purchases are subsidized through the tax code: Employer contributions are not taxed, which provided an estimated $126 billion subsidy in 2000 (including $85 billion through the exclusion of employer contributions from income taxation and another $32 billion through their exclusion from Social Security and Medicare HI taxes). This tax benefit is larger for those with higher incomes, since they face a higher marginal tax rate (see Figure 2).[6]

Figure 2
Tax Benefits for the Purchase of Employer-Sponsored Insurance



The current tax subsidy encourages provision of health insurance through employers. In addition, provision through employment forms a basis for risk pooling that is largely independent of health status, at least in most large firms.

This is one of the main reasons that the health insurance available through individual (non-group) markets is often more expensive than comparable coverage through an employer: the people who choose to obtain such coverage are those who think they are likely to have higher health expenditures, raising premiums and making the insurance even less appealing to those with lower expected costs. Furthermore, the administrative costs associated with these non-group plans are often much higher. (These problems also afflict the market for small employers.) State measures to reduce the cost or increase the availability of insurance in the non-group market are discussed in more detail below. Unfortunately, some of the regulatory approaches intended to improve the availability of affordable coverage have often done more harm than good, in effect discouraging participation in insurance markets.

In contrast, the health insurance credit will increase participation in these individual markets, increasing risk pooling and improving market functioning overall. An important question is the degree to which it would interfere with the functioning of employer-sponsored group markets by inducing some employers to stop offering insurance and some employees to stop taking the employer-sponsored insurance

[6] Estimates include the likelihood of receiving employer-provided health benefits and the value of the tax benefit of employer-provided health insurance. Source: John Sheils, Paul Hogan, and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," October 1999, The Lewin Group, Inc.

(ESI) they are offered. In practice, the health insurance credit has been structured to complement employer-sponsored insurance markets.

LIKELY EFFECTS ON INSURANCE PURCHASES

The Administration's health insurance credit would be available to people under 65 purchasing private health insurance coverage outside of plans offered by their employer or a spouse's employer. That is, both working and unemployed people who do not already have tax-subsidized, employer-provided insurance (or insurance through public programs such as Medicare or Medicaid) would be eligible.[7] Workers who are laid off and lose their insurance would be able to take advantage of the credit regardless of whether or not COBRA continuation coverage was available to them.

Individual Participation Decisions

Evidence suggests that the decision to purchase health insurance is quite sensitive to its cost. The President's proposal provides a refundable tax-credit of up to $1,000 for a single person and up to $3,000 for a family with two or more children, with the credit phasing out between $15,000 and $30,000 for single filers and between $25,000 and $60,000 for other filers purchasing policies for more than one person (or $25,000 to $40,000 if purchasing a policy for one person only). The effect of the credits on participation in individual insurance markets depends critically on the cost of the available insurance.

Some reports have placed the "mid-range" cost of family health insurance at approximately $7,000 per year, large relative to a $3,000 tax credit.[8] This estimate is likely overstated: it reflects the average cost of plans offered, not the best offer available. In addition, many of these plans often provide near first-dollar coverage—that is, all expenses, even predictable periodic and routine expenses, are covered, and there are almost no copayments, coinsurance, or deductibles.

Expensive "first dollar" coverage may not make good economic sense. First, minimal copayments lead to a disconnect between cost and value in health care decisions, contributing to rising health care costs (and patient frustration with managed care plans meant to control costs). As health care costs rise rapidly, such policies will be even less sustainable. Second, reliance on minimal copayments in both private managed care and government health insurance plans has led to significant regulatory intrusions and price controls, all of which adversely affect doctor-patient decision-making. However well-intentioned as an approach to limiting cost increases, such intrusions may make it more difficult for patients to get both appropriate treatment and protection from very high medical expenses. Third, patients will be much more likely to take an active interest in the value of the care they receive when they face at least a portion of the cost.

Analysis by the Council of Economic Advisers finds that Preferred Provider Organization (PPO) policies with significantly lower premiums are almost always available. These plans, which are not "first-dollar" plans but which provide effective health insurance assistance, are described in more detail in the Appendix. They typically cover all major types of medical services and treatment, have per person deductibles of $1,000 ($2,000 per family) while also covering preventive and emergency care, they generally provide significant discounts on all prescriptions and in-network services, and they support a full range of provider choices. The average premium for a plan of this type was less than $3,000, and was less than $1,000 for young individuals. For lower-income Americans, the proposed health insurance credit thus generally covers more than half of the premium the purchaser would face, and almost always covers more than a third.[9] Moreover, these prices are representative of actual coverage in the population, not the premiums available to just a few very healthy people. A recent study by the health insurance distributor eHealthInsurance found that three-quarters of premiums for individual health insurance plans that it sold were less than $2,000 and three-quarters of family pre-

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[7] There are other restrictions: The credit cannot be applied to the purchase of ESI, and people may not contribute to Archer MSAs in the same year that they claim the credit. Plans must meet minimum benefit standards. Those participating in ESI or public programs may not use the tax credits, although in some circumstances states may provide an additional contribution to individuals who purchase private insurance through Medicaid or SCHIP purchasing groups. Those over 65 (and thus eligible for Medicare) or anyone eligible for public insurance cannot claim the credit.

[8] See, for example, Center on Budget and Policy Priorities, "Unemployed Workers Need Help with Health Insurance," October 2001; General Accounting Office Report HEHS–00–104R.

[9] Low cost policies are substantially less common in states with community rating than in states without such regulation.

miums were less than $5,000.[10] Similarly, another study found that people with all but the most serious chronic illnesses were able to get affordable individual market insurance offers in every market examined.[11]

The type of plans that those using the health insurance credit are likely to purchase have distinct economic advantages. The growth of PPO and similar plans in the private sector reflects patients' desires for more choice, and the health insurance credit would allow individual purchasers to have the same choices. These policies function well as true insurance, providing excellent protection against large unanticipated expenses caused by a severe illness or needed surgery, and assistance with access to the full range of modern health care treatments. Patients who prefer lower copayments could choose a Health Maintenance Organization-style plan that used more restrictive networks and tighter control of care to keep the premium down. The presence of the credit may encourage insurers to offer even more plans catering to new insurance market purchasers, such as plans with good catastrophic coverage but deductibles high enough to keep premiums in line with the size of the credit. These plans would not only encourage the use of the credits, but would encourage responsible and informed use of health resources.

The analysis also documented substantial differences across geographic areas in the price of similar policies. This variation indicates that national averages can hide substantial heterogeneity in cost and may provide a poor representation of the market facing most families. One cause of this variation may be differences in the cost of care at the local level. (Another important source of variation is different state regulatory environments discussed below.) Having more involved and informed consumers of health care and greater individual participation may help reduce geographic disparities.

In order to infer the effect of health insurance credits on the purchase of individual insurance policies, we need to know not only what insurance policies are available, but how sensitive individuals' decisions are to the price of the insurance that they face. Estimates of this price sensitivity are difficult to obtain, but some studies suggest that individuals are quite sensitive to large subsidies, and are thus much more likely to buy insurance when they receive a 50 to 90 percent subsidy.[12]

Several different studies have examined the likely effects of the health insurance credit on insurance purchases. Pauly, *et al.* (2001) find that a $1000 refundable tax credit would likely increase the participation rate among the uninsured by 21 to 85 percent.[13] Gruber (2000) finds smaller effects, closer to 10 percent, but analyzes plans with premiums that are much more expensive than those described above. Other studies focus on average premiums, not the best offers available. Even with the most conservative assumptions, the health insurance credit would substantially increase participation in health insurance markets. If even 15 percent of those uninsured for a full year (or 10 percent of those uninsured for part of a year or more) take advantage of the health insurance credit, 6 million people would be newly covered. In addition, the credits would encourage those already purchasing non-employer coverage to purchase more comprehensive policies.

LIKELY EFFECTS ON MARKETS

The health insurance credit would likely significantly increase participation in non-employer health insurance markets and increase the generosity of coverage selected. This increased, more generous participation would both increase the pooling of risk and reduce administrative costs.

Individual Health Insurance Markets

The health insurance credit could increase the participation in individual markets of a wide cross-section of Americans. As shown in the Appendix, it would cover a

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[10] eHealthInsurance is a leading national health insurance distributor of individual and small group plans, and in 2001 analyzed 20,000 recently purchased policies. More than 80% of the policies sold had comprehensive coverage. 75% were PPO plans, and 71% of those PPO plans had deductibles of $1,000 or less. http://www.ehealthinsurance.com/ehealthinsurance/eHealth2.pdf.

[11] Pollitz, Sorian, and Thomas, *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health,* Kaiser Family Foundation, June 2001; and eHealthInsurance Services, Inc. The original Kaiser study investigated whether the mock applicants with different preexisting health conditions were rejected by any insurer, not whether they actually received offers, and reported average offers, not the best offer, which is more indicative of the cost that they would actually incur. All of the mock applicants received offers in every market tested, with the exception of an HIV positive applicant. The best offer was often not much more expensive than the offer for healthy mock applicants.

[12] Marquis and Long, *Worker demand for health insurance in the non-group market,* Journal of Health Economics, v. 14 (1995).

[13] Note that their hypothetical credit had a somewhat different structure.

lower percentage of the premium for individuals over 50 and those with chronic illnesses, for whom rates in the individual market are higher. While there is little evidence on this point, older and sicker people are likely less sensitive to the price of insurance and would value the credit more highly, so even though their premiums might exceed the maximum credit by more, they may increase participation in individual markets just as much as their younger, healthier counterparts. This broad increase in participation, especially of younger and healthier people, would improve the pooling of risk in the individual market (since insurers cannot perfectly underwrite individuals' health risks).

There are several other regulatory reforms that affect the efficiency and availability of insurance through individual markets. In an effort to subsidize the insurance purchase of those with high expected medical expenses, some states have implemented regulations that limit or prohibit the extent to which insurers can vary prices based on expected expenses. Some of these regulations have the perverse effect of driving people out of individual insurance markets.

States have several regulatory devices at their disposal, including restrictions on the variation in premiums (rating bands), requirements on the fraction of premium receipts that must be paid out in benefits (loss ratio restrictions), mandated benefits, restrictions against the exclusion of preexisting conditions, community rating and guaranteed issue. In community rated states, insurers must offer all purchasers in the same "community" the same rate.[14] By prohibiting insurers from charging higher premiums to those in high-risk categories and in effect averaging costs of the high risk people with the lower risk people, this regulation is intended to hold down the premiums for those who are expensive to insure. States with guaranteed issue regulations require that insurers write policies for all comers. When coupled with community rating (such as in Maine, New Jersey, New York, and Vermont), this policy means that even those with very high expected health care costs will face the same price as healthy people. The drawback of these policies and many other forms of regulation is that the premiums facing most purchasers may be higher than they would be in the absence of regulation, since the premium collected must be sufficient to cover the expected expenses of the group. Given higher premiums, the healthiest individuals (those with low expected costs) may chose not to buy policies. Regulation thus provides another cause for adverse selection, and a spiraling upward of premiums.

As an alternative to policies such as community rating, states can establish high-risk pools.[15] These pools are often subsidized with general revenues or through taxes on insurance companies. Broadly funded high-risk pools can subsidize the insurance purchase of people with consistently high medical expenses, without making health insurance unappealing for others. Today, 29 states have adopted high-risk pools (including some states, such as Kentucky and Washington, that used to have guaranteed issue but found that it severely undermined their individual insurance markets).[16] States with adequate, broad-based funding for their risk pools are providing good insurance at affordable rates for people who would otherwise face high premiums in the individual market, and are doing so without driving up rates and reducing coverage.[17]

Finally, lower income people can also use Administration's health insurance credit in non-employer purchasing groups, including private affinity groups and state-sponsored purchasing pools. Many states have already established purchasing pools that allow individuals enrolled in their Medicaid or SCHIP programs to choose from competing private plans. All states have competitive purchasing pools for their state enrollees. Thus, states generally have an infrastructure in place to provide a group coverage option, giving people using the credit another option for obtaining affordable health insurance choices.

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[14] A community can be defined broadly, such as all individuals in the state, or more narrowly, with some differences permitted by age and/or geographical location, for example. Premiums in community rated states cannot vary with factors such as occupation or health status. Some states have modified community rating, allowing some, but only limited variation based on health factors.

[15] The National Association of Health Underwriters found premiums for a 53 year old male in 14 states with high risk pools. The average premium in these 14 states was $5086. The average premium in our data for the 55 year old single male was $2597. The high risk policies sought had $500 deductibles and generally had more comprehensive coverage.

[16] Communicating for Agriculture, What is a Risk Pool?, 2002, www.cainc.org/riskpools/commonwealth.html.

[17] Communicating for Agriculture, op cit; Communicating for Agriculture/National Association of State Comprehensive Health Insurance Plans, Comprehensive Health Insurance for High-Risk Individuals, 1999.

Employer-sponsored Insurance Markets

The generosity of the credit would also influence the cost of the expansion of coverage. A very generous credit would induce more people to obtain coverage but, depending on its design, might also draw more workers away from current employer coverage, either by leading them to opt out of taking up coverage that their employers offer or by inducing employers to stop offering coverage. The result would be a relatively expensive incentive with relatively less net effect on coverage.

Employees who are eligible for ESI may forgo employer insurance and voluntarily enter the non-group market if doing so allows them to select a policy that better meets their specific needs. Single, healthy individuals may wish to use their credit to purchase less generous coverage than the coverage offered by their employer. Employers may choose not to offer health insurance at all if many of their employees can take advantage of the credit and purchase insurance individually, and receive taxable wages in lieu of employer health insurance contributions. Insurance in the non-group market carries higher administrative costs, which implies that such an outcome would not be efficient in the short run. In the long run, as discussed above, increased participation in individual insurance markets may improve their functioning such that they have similar risk pooling and administrative costs as group markets.

Such arguments suggest that a tax credit that is too large may disrupt the ESI market. In this case, the phase-out of the proposed health insurance credit and the cap on the maximum amount are important features to ensure that there are minimal disruptions to the ESI market. Those low-income Americans who are eligible for the largest credit are less likely to have employer-sponsored health insurance. About 80 percent of uninsured workers are not offered health insurance by their employers.[18] Only 36 percent of people under age 65 with income below 200 percent of the Federal poverty line have ESI, while 77 percent of those above do.[19] Furthermore, employers make the decision to offer health insurance based on all of their employees, so they are unlikely to stop offering insurance simply because a minority of their employees become eligible for the health insurance credit. Most employees would be significantly better off with the uncapped, untaxed payments for their health insurance, and with the administrative savings of group plans, than with the capped credit and some additional taxable wages. Moreover, even if this minority of employees dropped employer coverage because they could get more affordable non-employer insurance, there would not be a large effect on overall employer health insurance costs. Consequently, the impact of the proposed credit on employer health insurance coverage would be minimal, and the majority of individuals taking up the proposed health credit would be those who were either previously uninsured or previously covered in the non-employer insurance market.

By comparison, research indicates that 50 percent or more of those who became eligible for Medicaid in the expansions of the late 1980s and early 1990s lost private coverage, suggesting that providing near first-dollar coverage (even in a government insurance plan) requires much more substantial government funding to achieve comparable reductions in uninsured rates.[20]

Some health policy experts and Members of Congress have proposed a broader-based refundable tax credit—one that would also provide significant new subsidies to all workers with employer-provided coverage. Because so many workers have employer coverage already, however, a tax credit for employer coverage would have a far greater budgetary impact, and a much larger share of its costs would go toward existing rather than new health insurance coverage. To limit the additional budgetary costs, many experts have proposed a gradual transition from the current tax exemption to a system of tax subsidies for employer coverage that relies more on credits. Although such a transition would probably encourage lower cost employer coverage and increase the takeup of employer coverage by lower income workers, it could have a significant impact on current employer plans, union negotiations, and other issues affecting worker compensation. Thus, it seems less likely to be effective as an incremental, immediate step to improve insurance coverage significantly.

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[18] Garrett and Nichols, Workers without health insurance: who are they and how can policy reach them, Urban Institute, 2001, cited in Blumberg, Health insurance tax credits: potential for expanding coverage, Urban Institute, August 2001.

[19] Department of Health and Human Services tabulation of the March 2001 CPS, which includes data from 2000.

[20] Cutler and Gruber, Does Public Insurance Crowd Out Private Insurance?, Quarterly Journal of Economics, 111(2), May 1996, 391–430.

Labor Markets

Because this credit is available to all low-income uninsured Americans, it will provide both increased options for workers and an improved safety net for the unemployed. It can help ease transitions between employment, dislocation, and reemployment without distorting labor markets. Unlike employment-based insurance, part-time and seasonal workers will be able to keep the coverage they purchase with the health insurance credit even if their jobs change.

CONCLUSION

The Administration's health insurance credit will allow millions of Americans to purchase good insurance through private markets. It will improve the functioning of individual insurance markets, and will encourage high-value, high-quality care.

APPENDIX: THE COST OF HEALTH INSURANCE IN INDIVIDUAL MARKETS

The Council of Economic Advisers performed quantitative analysis to document the likely effects of the health insurance credit on the purchase of health insurance. A key component of this is the cost of the insurance plans available through non-group markets.

Data Description

To analyze the purchasing power of the proposed health insurance tax cut, we compiled a data set of sample premiums. Using the web site www.ehealthinsurance.com we collected data on premiums for low-cost traditional indemnity (i.e., Fee-for-Service or FFS) plans and low cost Preferred Provider Organization (PPO) policies, in which patients can see physicians outside their network, but with higher copayments. We obtained observations for one large and one small city in each state. In each case we priced policies for six hypothetical purchasers.[21] Our total number of observations is 1020 (2 plans x 6 families x 50 states x 2 cities, less missing values for cases in which we were unable to find policies that satisfied our criteria).[22] Although the sample is small, it provides a starting point for an investigation of the affordability of insurance in the individual market. The purchaser and plan types included in the sample were:

Purchasers:	Plan Characteristics:
• 55-year-old single male	• $1000 per person deductible
• 25-year-old single male	• $2000–$3000 family deductible
• 25-year-old couple	• covers office visits
• 55-year-old couple	• covers emergency room care
• 25-year-old mother and daughter	• 20% coinsurance or $30 copayment
• 25-year-old couple with two children	

We attempted to obtain quotes for plans with characteristics as close as possible to those listed above. While all the plans we sampled cover emergency room care and all but 12 (those in New York City) cover office visits, the deductibles and coinsurance/copayments are occasionally higher or lower than our specifications. Overall, 92 percent of our single policies have deductibles of $1,000; 5 percent have higher and 3 percent have lower deductibles. Eighty-one percent of our family policies have deductibles of $2,000 or $3,000, with 8 percent lower and 11 percent higher. All of the plans have coinsurance of 20 percent, except for the plans in New York City, which have no coinsurance, and the plans in Boston and Brockton, Massachusetts, which have 10 percent coinsurance. We also assumed that the individuals were in good health, with no preexisting conditions, and were not smokers.

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[21] Plan premiums typically vary by age. We choose one "young age" and one "old age." Premiums for family policies vary by the age of the adults.

[22] We were unable to obtain information on regulations in the District of Columbia. We found no individual policies available in Hawaii and no PPO plans in Maine, New Hampshire, or New Jersey.

Premiums and the Credit

This section provides summary information on the types of policies available.[23] The discussion highlights not only national averages, but also the distribution of premiums relative to the proposed health insurance credit.

Premiums vary substantially across states and across types of purchasers. Table 1 has summary statistics for PPO premiums by family type and appendix table A1 shows PPO premiums for the two cities in each state by type of purchaser.[24] For a family of four, annual premiums vary from $1,272 for Bloomington, Illinois to $9,675 in Boston, Massachusetts (the Boston policy has relatively generous benefits).[25] The average price for a family of four is $3,287.[26] Premiums for young single males are substantially lower, averaging just $975, or $25 *below* the proposed health insurance credit.[27] Premiums for individuals in their 50s are much higher. The average premium for a 55-year-old male is $2,749.

Table 1: Mean Annual Premium for PPO Plans

Characteristic	Average	Median	Minimum	Maximum
Younger Male	$975	$772	$504	$4094
Older Male	$2749	$2464	$1524	$6722
Younger Couple	$2142	$1729	$1032	$7370
Older Couple	$5145	$4613	$2904	$12099
Mother and Child	$1931	$1518	$852	$7224
Family of four	$3287	$2683	$1272	$9675

The differences in the prices faced by older and younger Americans are substantial: the average premium for an older couple is over $5,000 compared to $2142 for a younger couple. These premiums are for a couple aged 55; older couples (not yet eligible for Medicare) would face higher prices.[28] However, there is also evidence suggesting that older Americans may value health insurance more than younger Americans and may therefore be more willing to devote a larger fraction of their income to health insurance premiums, so that a $1,000-$2,000 tax credit would be sufficient to stimulate purchases.

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[23] In the following, we focus on PPO premiums because they are lower and thus more likely to be selected by those helped by the tax credit. Also, PPOs are the most commonly offered type of plan by employers. In 2000, 75 percent of large employers offering health insurance coverage offered a PPO plan, compared to 25 percent for a traditional indemnity plan and 51 percent for an HMO (Mercer/Foster Higgins Mercer/Foster Higgins, National Survey of Employer-Sponsored Plans, 2000). Premiums for FFS plans follow the same pattern, but are higher.

[24] These premiums are similar to premiums that were actually purchased. In the 1996 Medical Expenditure Panel Survey, the average premium paid by single policy holders for plans purchased in the non-group market was $1573; half of the individual premiums were between $600 and $1,992. The average family policy was $2,651; half of the premiums were between $600 and $3650. (Accounting for the potential accidental reporting of supplemental plans by eliminating the lowest 5 percent of premiums raises the average single plan cost for 18 to 39 year olds by only $150.) There was substantial variation both by age and by specific plan. The average individual premium in the MEPS ranged from $1230 for those less than 40 years old to $1976 for those 55–64 years old. (Statistics provided by Jessica Banthin at the Agency for Healthcare Research and Quality.)

[25] The average premium in 2001 for employer-provided health insurance was $2,652 for single plans and $7,056 for family plans (Kaiser Family Foundation, 2001 Kaiser/Health Research and Educational Trust Survey). The average yearly contributions for employees for whom some contribution was required was $840 for a single coverage and $2868 for a family plan. Fifty percent of employees paid no contribution for single coverage but only 18 percent for family coverage (Mercer/Foster Higgins, National Survey of Employer-Sponsored Plans, 2000).

[26] Because deductibles are measured on a per person basis with annual family caps of $2000-$3000 it is possible for a family with these policies to have substantial out of pocket expenses. They are, however, protected against large expenses that might be incurred with a hospitalization, chronic condition, or serious illness.

[27] Although we did not conduct as thorough an analysis, premiums for young women appear to be only slightly higher on average (approximately $50 to $100 higher) and identical in some states (these policies typically do not include maternity coverage).

[28] The fraction of employers providing retiree coverage has fallen sharply in recent years (Employee Benefits Research Institute, Health Benefits Data Book, Washington, DC, 1999).

Prices vary substantially across cities and states. We examine the distribution of premiums with respect to the credit to which the purchaser would be entitled. Nearly three quarters of the PPO plans for young single men had premiums less than the proposed $1000 health insurance credit and over 90 percent cost less than $2000. Thus the health insurance credit would provide young men substantial assistance in purchasing a policy. In contrast, the subsidy covers much less of the policy premium for older single men: only 1 percent of plans have premiums below $1000 and just 17 percent of plans were less than $2000. Younger families fare much better than older Americans. A $3000 subsidy would cover half the PPO premium for a family of four in more than 90 percent of the plans. If children in a low-income family are eligible for SCHIP or Medicaid, then a $2000 credit would cover all of the cost for the mother and father in more than 70 percent of the plans.

These premiums are for plans that do not provide first-dollar coverage, yet as noted earlier, provide comprehensive coverage for large expenses. Plans with lower annual deductibles will be more expensive. To investigate the difference, we priced health insurance policies with a $500 deductible but coverage similar to our sample in other dimensions.[29] We collected this information for families in 10 states, and premiums were approximately 20 percent higher. The premium data presented assume that the individuals are in good health and are non-smokers. Just as premiums increase with age because expected medical expenses increase, plan availability and premiums also change with the underlying health of the beneficiary. There is also substantial variation in price across insurers as well as variation in the quality of service provided. For example, in Kansas City, Kansas, premiums for family policies that fit our criteria range from $182.50 to $434. Consumers need to shop carefully for plans, comparing prices and coverage to find the plan that best suits their needs.

Mr. MCCLELLAN. That study indicates that the credit would provide good, affordable coverage options for almost all persons who are eligible, particularly in conjunction with its use in high-risk pools and other purchasing group arrangements. Altogether, 6 million or more people who otherwise would be uninsured for some or all of the year would get coverage under this proposal.

Moreover, the analysis by CEA, as well as the analysis of the credit by Treasury professional staff, indicate that the vast majority of persons who use the credits would be those who were either previously uninsured or those who are currently struggling to purchase nongroup health insurance on their own. About 16 million people in this country buy nongroup coverage today, and receive little or no assistance from the government to do so.

Only a very small fraction of those with current employer coverage would use the credit. So while very attractive to those without good employer coverage today, the credit is generally not a better deal than the current uncapped tax subsidy of $120 billion per year for employer-sponsored coverage.

This proposal is one key element in a broad set of Administration proposals to help us create a more patient-centered health care system. The President believes that our private health system is the best in the world because it encourages and rewards innovation to get the best treatments to the patients who need them. He also believes that our health system faces serious problems today, problems of rising costs, problems of frustrations of doctors and patients that they are losing control to health maintenance organization (HMO) and government bureaucrats.

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[29] The median deductible for in-network individual coverage for employer sponsored policies was $250 in 2000 (Mercer/Foster Higgins, National Survey of Employer-Sponsored Plans, 2000).

He believes that the best way to preserve the best features of our private, innovative health system while addressing these challenges is to find solutions that are based on trust in patients working with health care professionals. By giving all Americans access to affordable health care coverage options, we will not only enable Americans to get up-to-date coverage that meets their needs, we will also encourage high-quality, high-value care that is continuously getting better, and that has been the hallmark of our health care system.

The Administration wants to work closely with Congress in a bipartisan fashion to make this vision a reality. At yesterday's event sponsored by the Robert Wood Johnson Foundation, there were many stories presented of what a difference good coverage options can make. Before coming to the Administration, while I was a Professor at Stanford, I also practiced in our internal medicine clinic there, and I saw many stories myself of patients with chronic illnesses and other health problems who had difficulty getting ongoing care because of lack of health insurance.

We are pleased by the broad support in the community by groups on the right and left, and in this Committee, for proposals to move forward and to find common ground on addressing the problem of the uninsured now. I think the Nation's uninsured have good reason to be optimistic that help is coming soon. Thank you.

[The prepared joint statement of Mr. Weinberger and Mr. McClellan follows:]

Statement of the Hon. Mark Weinberger, Assistant Secretary for Tax Policy, U.S. Department of the Treasury, and Hon. Mark B. McClellan, Member, Council of Economic Advisers

Mr. Chairman, Congressman Rangel, and distinguished Members of the Committee, we appreciate the opportunity to discuss with you today the President's proposals for tax credits for the purchase of health insurance.

Mr. Chairman, the Administration looks forward to working with Congress, in a bipartisan manner, to address the pressing need to expand access to health insurance for uninsured Americans. Almost 40 million Americans are reported to go without health insurance coverage for an entire year, and as many as 20 million more are without health insurance coverage during some part of the year. In addition, millions more Americans are struggling to afford rising health insurance premiums, with little help from the government. The scope and persistence of this issue highlights the importance of our making progress this year.

The President's proposals to introduce health credits for the purchase of health insurance will enable millions of Americans to purchase private health insurance, improving the functioning of private markets, empowering patients to make informed decisions, and increasing utilization of high quality health care. This proposal is part of a broader vision for promoting health care quality and access by developing flexible, market-based approaches to providing patient-centered health care coverage for all Americans.

Health insurance credits use the infrastructure of the tax system to expand access to health insurance. They are a common element of proposals from both Republicans and Democrats. Many of the distinguished Members of this Committee have supported such proposals and sponsored such legislation in prior sessions of Congress. We must seek to bridge partisan divides to come to agreement on this key issue which enjoys such wide bipartisan support. To help do so, the President has proposed health insurance credits that build on the best features of previous proposals, and that include new innovations to address past criticisms of tax credit proposals. And the President's budget backs up his agenda for using health insurance credits to improve access to good coverage with over $100 billion in funding. We hope that these steps forward will provide a foundation for decisive action in Congress this year to address the serious problem of health care affordability and the uninsured.

The Problem of the Uninsured

In 2000, 14 percent of Americans reported that they were uninsured for the entire year. They may go without effective health care, or may rely on inefficient episodic care at hospital emergency rooms. As a result, our health system spends more than it should on complications of diseases that could have been prevented and on inefficient ways of delivering health care. Even worse, the absence of insurance makes it harder for Americans to work with health care professionals to stay healthy.

The uninsured population does not consist only of the poor or the unemployed. In 1999, 81 percent of the uninsured population were in families with at least one full-time worker. Furthermore, while 36 percent of the uninsured had incomes below the poverty line, a large fraction, 29 percent, had incomes between 100 and 200 percent of poverty. Nearly three-quarters of the uninsured below 200 percent of poverty are adults, many of whom do not live in households with children.

Insurance coverage differs significantly by race and ethnicity. In 2000, 32 percent of Hispanics were uninsured, compared to 20 percent of blacks and 19 percent of Asians. In contrast, just 10 percent of whites were uninsured.

The benefits of increasing participation in health insurance markets extend beyond the ability to have more control over their health care and health realized by the individuals themselves. First, although some people without insurance could receive subsidized basic health care through emergency rooms, it is a very expensive way to provide care, and it is either paid at governmental expense or is uncompensated care that imposes higher costs on others. Second, improved public health through expanded health insurance coverage is important to control the spread of disease. Third, as discussed below, greater participation in insurance markets allows better pooling of health risks—the insurance markets themselves work better.

Problems in Health Insurance Markets

The major goal of health insurance is to allow individuals to join together to reduce their risk of high medical expenses by sharing that risk. Individuals trade the uncertainty of very unpredictable health care costs for the greater certainty of a known premium and protection from very high medical expenses. An important element of insurance is thus the "pooling" of risk—people sign up for insurance before they know how much they will spend on health care, and then the premiums of those who have low expenses help subsidize spending on those with high expenses.

Another important goal of health insurance is to make sure that Americans have access to the most innovative, high-value health care available. The American health care system leads the world in Nobel prizes and in the development of new drugs, devices, and other treatments to prevent and cure illnesses. To make sure these impressive medical breakthroughs translate into good care, health care coverage must be innovative as well. One need look no further than the lack of prescription drug coverage in Medicare to understand the consequences of out-of-date health care coverage. In the years ahead, far more breakthroughs are possible—such as customized treatments based on a clear understanding of an individual's genetic makeup, and specialized "disease management" programs that rely on the Internet and other modern telecommunications technologies that allow patients with chronic illnesses not only to stay out of the hospital, but also out of the doctors office. Innovative health care coverage is essential for creating an environment for medical practice that encourages innovation, value, and continuous improvement in health care.

Several problems can interfere with the ability of insurance markets to achieve these goals. A key problem is lack of choice and competition. As the President has said, our health care system works best when it is centered on helping patients work with health care professionals to decide the best possible treatments. To give control to patients, Americans need the opportunity to choose the health care coverage that is best for them. Without good choices, patients do not have the power to make sure that they are getting the best value from the health care system for their own needs. Instead, government or health plan bureaucrats effectively make decisions for them about what is covered, how their care is reimbursed, and how treatments are provided. In other countries, this has led to queues for treatments, poor quality, and lagging availability of innovative care. Our country has chosen another path: private sector health care based on trust in patients and their physicians. This path rewards innovation in delivering the best possible health care. But the tremendous potential of our health care system is threatened when patients do not have choices about how to get health care coverage. For this reason, the President strongly believes that we must take action to improve the health care coverage options available to Americans.

A second problem is adverse selection. If only individuals whose health insurance expenditures are likely to be high sign up for insurance, then the pooling of risk

that is the key to insurance is undermined. Just as individuals with higher expenses want more insurance, insurance companies want customers with lower expenses, and may design their plans to appeal to those with low risk.

Health insurance credits can help solve these problems in health insurance markets by making more coverage options affordable, increasing participation, and reducing adverse selection. Greater affordability and participation will encourage competition to provide coverage that delivers high-value, innovative care. Thus, well-designed health insurance credits reinforce the best features of our private, highly innovative health care system.

In the remainder of our testimony, we discuss the critical design issues in more detail. Design issues include the mechanics of how people actually use the credits to get assistance with health insurance purchases. To work effectively, especially for families with modest means, credits must be refundable, advanceable, and nonreconcilable.

- Refundability means that the value of the credit does not depend on taxes owed; even persons who owe no taxes can still receive its full value.
- Advanceability means that those eligible for the credit have the option of using it when they are actually purchasing insurance, to reduce their monthly premium payments, rather than having to wait until they file their tax return at the end of the year.
- Nonreconcilability means that eligible persons do not have to wait until they know their actual income at the end of the year before they know exactly how much assistance they are eligible to receive. Rather, they can be confident that—as long as they are not committing fraud—they are entitled to the full value of an advanceable credit.

Health insurance credits are not the only promising direction for a health care policy that helps patients get high-quality, innovative care. There is no single approach that can work with the best features of all of our health care institutions to help ensure that our health care system remains the best in the world. Given the need for a broad approach to this problem, the President supports both an immediate temporary health insurance tax credit for displaced workers, as contained in the economic security package, and a permanent new health insurance tax credit to expand health insurance coverage for others that is not dependent on employment status. The President's Budget also contains a number of other initiatives designed to expand health insurance coverage. These include: (i) an above-the-line deduction for the purchase of long-term care insurance; (ii) expanded flexibility of health flexible spending arrangements; (iii) reform and permanent extension of Archer Medical Savings Accounts, to permit Americans to set up health accounts to help them meet the out-of-pocket payments required in many health plans that do not restrict choices of doctors and treatments; and (iv) an additional personal exemption for home caretakers of family members.

These proposals are designed to target a diverse group of people while improving the functioning of insurance markets. In addition, as the President outlined in an address on his health care agenda on Monday, the President's budget includes many other proposals to give all Americans access to high-quality, affordable options for health care coverage. Together, these proposals will provide health security and additional health insurance coverage for millions of Americans, while preserving the best features of our highly innovative health care system.

Permanent Health Insurance Credit for Americans Who Do Not Have Employer-Provided Coverage

Current law provides a number of tax incentives for individuals to obtain health insurance coverage. Employer-provided health insurance and reimbursements for medical care are generally excluded from gross income for income tax purposes and from wages for employment tax purposes. Active employees participating in a cafeteria plan may pay their employee share of premiums and other medical care expenses on the same pre-tax basis. In addition, for self-employed individuals who are not eligible for subsidized employer coverage, 70 percent of health insurance premiums are deductible for 2002, and 100 percent are deductible for 2003 and thereafter.

Proposal

However, as noted above, millions of Americans still are without health insurance coverage. The refundable health insurance credit proposed in the President's Budget is designed to provide these incentives to assist uninsured individuals in purchasing health insurance.

The credit is refundable, so even those without income tax liability can receive the benefit of the credit. In addition, the largest subsidies will be targeted to low-income families, and only individuals who are not covered by public or employer-based health insurance will be eligible for the credit. Therefore, the credit will be of most help to individuals who are most likely to be uninsured—childless adults who are generally not eligible for public insurance and persons in families with incomes too high to participate in public insurance programs and too low to find affordable coverage options in the private market. The credit will help families who prefer the innovation and flexibility of private insurance options to public insurance, and will enable families to obtain coverage for the entire family from the same providers. The credit is also designed to be available at the time the individual purchases health insurance. That is, people eligible for the credit can receive it in advance, before filing their tax returns, to reduce their monthly checks for insurance premium payments. Finally, because the credit is based on income from the previous year, it is nonreconcilable—earning more income in the current year does not reduce the value of the credit. We believe that the availability and certainty of the advance credit will increase the credit's attractiveness, making it more effective in expanding health insurance coverage.

The proposal would create a refundable, advanceable income tax credit for the cost of health insurance purchased by individuals under age 65. Individuals participating in public or employer-provided health plans would generally not be eligible for the tax credit. In addition, individuals would not be allowed to claim the credit and make a contribution to an Archer MSA for the same taxable year. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses.

The credit would provide a subsidy of up to 90 percent of a capped amount of health insurance premiums. The maximum credit would be $1,000 per adult and $500 per child for up to two children. The maximum subsidy percentage of 90 percent would apply for low-income taxpayers and would be phased down at higher incomes. While the subsidy percentage would be phased down with income, the maximum premium that could be taken into consideration in calculating the credit amount would be fixed at $1,111 for an adult and $556 for a child. These dollar amounts would be indexed by the Consumer Price Index for all-urban consumers.

Individuals with no dependents who file a single return and have modified Adjusted Gross Income (AGI) up to $15,000 would be eligible for the maximum subsidy rate of 90 percent and a maximum credit of $1,000. The subsidy percentage for these individuals would be phased down ratably from 90 percent to 50 percent between $15,000 and $20,000 of modified AGI, and then phased out completely at $30,000 of modified AGI. For example, the maximum credit for these individuals would be $556 at $20,000 of modified AGI.

All other filers (including single filers with dependents, heads of households, and joint filers) with modified AGI up to $25,000 would be eligible for the maximum subsidy rate of 90 percent, and the maximum credit of $1,000 per adult and $500 per child for up to two children. The subsidy percentage would be phased out ratably between $25,000 and $40,000 of modified AGI in the case of a policy covering only one individual, and between $25,000 and $60,000 of modified AGI in the case of a policy or policies covering more than one person.

The maximum credit for these other filers would vary by income and the number of adults and children covered by a policy. For example, the maximum tax credit would be $3,000 for a low-income family with modified AGI up to $25,000 who obtained a policy covering two adults and two or more children. The maximum credit would be phased down to $1,714 as the family's modified AGI rose to $40,000. For a policy covering only two adults, the maximum credit would be $2,000 for families with modified AGI up to $25,000 and $1,143 for families with $40,000 of modified AGI.

Examples of the maximum credit:

(1) INDIVIDUALS WITH NO DEPENDENTS FILING A SINGLE RETURN

Modified AGI	$15,000	$20,000	$30,000
Maximum Credit	$1,000	$556	$0

(2) OTHER FILERS OBTAINING A POLICY COVERING ONLY ONE ADULT

Modified AGI	$25,000	$30,000	$40,000
Maximum Credit	$1,000	$667	$0

(3) OTHER FILERS OBTAINING A POLICY COVERING TWO ADULTS

Modified AGI	$25,000	$40,000	$60,000
Maximum Credit	$2,000	$1,143	$0

(4) OTHER FILERS OBTAINING A POLICY COVERING TWO ADULTS AND ONE CHILD

Modified AGI	$25,000	$40,000	$60,000
Maximum Credit	$2,500	$1,429	$0

(5) OTHER FILERS OBTAINING A POLICY COVERING TWO ADULTS AND TWO OR MORE CHILDREN

Modified AGI	$25,000	$40,000	$60,000
Maximum Credit	$3,000	$1,714	$0

Individuals could claim the tax credit for health insurance premiums paid as part of the normal tax-filing process. Alternatively, the tax credit would be available in advance at the time the insurance is purchased. Individuals would reduce their premium payment by the amount of the credit and the health insurer would be reimbursed by the Department of Treasury for the amount of the advance credit. Eligibility for the advance credit would be based on the individual's prior year's tax return.

The credit would be used for qualifying health insurance purchased in the non-group market. In addition, qualifying health insurance could also be purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. At state option, effective after December 31, 2003, the tax credit would be allowed for certain individuals not otherwise eligible for public health insurance programs to purchase insurance from private plans that already participate in State sponsored purchasing groups, such as Medicaid, SCHIP, or state government employee programs.

States could, under limited circumstances, provide an additional contribution to individuals who claim the credit in connection with purchases of private insurance through Medicaid or SCHIP purchasing groups. The maximum state contribution would be $2,000 per adult for up to two adults for individuals with incomes up to 133 percent of poverty. The maximum state contribution would phase down ratably reaching $500 per adult at 200 percent of poverty. Individuals with income above 200 percent of poverty would not be eligible for a state contribution. States would not be allowed to provide any other explicit or implicit cross subsidies.

The health insurance tax credit would be effective for taxable years beginning after December 31, 2002.

Discussion

This proposal contains a number of important and innovative features. First, the credit amount varies with family size and composition, reflecting the impact of these factors in the non-group market. For example, two adults face higher premiums, and will receive a larger credit, than a single adult. Likewise, families with children face higher premiums, and will receive a larger credit, than families without children. Second, the credit is "advanceable," and eligibility for the advance credit is based on the individual's prior year's tax return. This design guarantees certainty of the amount of the credit and makes it available at the time individuals purchase health insurance; they do not have to wait until they file their tax returns after the year is over. Third, the proposal allows the credit to be used toward private insurance purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. This provision will increase coverage options, achieve economies of scale, and encourage risk pooling in the non-employer market.

In designing a policy to expand health insurance coverage to the uninsured, one concern is that the policy does not inadvertently decrease health insurance options to those presently insured. Some have suggested that if the purchase of health insurance outside of the employer market became sufficiently attractive, employers might stop providing health insurance coverage to their workers, potentially resulting in a net decrease in health insurance coverage among the population. Based on these concerns, the Administration's proposal has been carefully designed to avoid "crowdout" of subsidized employer coverage, and thus will expand coverage substantially. Several elements of the credit design contribute to this desirable result. Most importantly, low-income individuals and families, who are least likely to have employer-based health insurance, will receive the largest incentives under this pro-

posal. In addition, the health credit subsidy rate decreases with income, requiring larger individual contributions for any given policy and making it a less attractive alternative to the employer-provided insurance at higher income levels. The health credit is further limited by a cap on the amount of premium eligible for subsidy. Although this capped premium amount is adequate for many individuals to purchase health insurance, it is typically less generous than most employer plans.

The credit is also designed to be targeted to the individuals who are most likely to be uninsured during at least some part of the year. Approximately six million such individuals are expected to gain coverage as a result of the credit. Most of these individuals are neither offered employer-based insurance nor eligible for public programs over the course of their uninsured spells. The credit will provide a strong new incentive for these persons to find coverage in the individual market. It will also allow many families that are already purchasing coverage in the individual insurance market, and receiving very little government assistance in doing so, to obtain better coverage at a lower out-of-pocket cost.

The credit will significantly increase participation and quality of coverage in non-group health insurance markets. These improvements will not come at the expense of employer group markets. Those low-income Americans who are eligible for the largest credit are less likely to have employer-sponsored health insurance. Around 80 percent of uninsured workers are not offered health insurance by their employers. Only 36 percent of people under age 65 with income below 200 percent of the federal poverty line have employer-sponsored health insurance, while 77 percent of those above do. Furthermore, the generosity of employer-sponsored insurance is determined by the tax benefits for the group of employees, not the attractiveness for low-income employees only. Tax benefits for employer coverage will remain large for the middle- and higher-income workers that make up most of the employees of most firms that offer generous employer-sponsored plans. Those workers' incomes are too high for them to get more attractive benefits from the proposed health credit. Thus, employer-provided coverage will remain more attractive for firms that offer generous coverage today. That is, the phase-out and cap on the credit ensure that employers will continue to offer insurance and that employees will continue to enroll. The proposed credit will simply eliminate an inequity in the current system that disadvantages workers without employer coverage, helping them to purchase the coverage that meets their needs.

Recent research also suggests that the credit would provide good, affordable health insurance options for the vast majority of individuals who are eligible for the credit. This is the subject of a detailed analysis by the Council of Economic Advisers. The minority of less healthy persons who lack any insurance options and find insurance unaffordable or unavailable for their health status in the individual market could use the credit to buy into the state high-risk pool for which the premium is usually subsidized. The proposal also permits certain low-income individuals to purchase private insurance through other state-sponsored health insurance purchasing groups. Coupled with the Administration's other proposals for strengthening employer coverage and for providing more assistance to individuals with the greatest health care needs, the health credit is a critical part of our approach for ensuring that all Americans have good, affordable private health care coverage options.

This proposal is part of a broader Administration goal of achieving more patient-centered health care by encouraging innovations in the financing and delivery of health care services. Market-based approaches such as this will encourage high-quality, high-value coverage by giving patients the ability to choose the coverage that best meets their needs. In turn, innovative coverage will permit Americans to benefit from the tremendous potential of our health care system in the 21st century.

Health Insurance Credit for Displaced Workers

Because the permanent health insurance credit would not be effective until next year, the President continues to support the immediate health insurance credit for displaced workers, which was one component of the economic security bill supported by a bipartisan group of centrist Senators and passed by the House last December.

The health credit for displaced workers is a refundable, advanceable tax credit that could be claimed by unemployed workers for a period of up to 12 months. The credit can be used to offset 60 percent of the cost of health insurance premiums for unemployed workers and their families.

The credit can be applied to the purchase of COBRA or "super-COBRA" continuation coverage, and other types of qualified private non-employer health insurance. Eligible unemployed workers include those receiving unemployment insurance benefits and those who would be eligible for benefits except that their rights to benefits were exhausted or the period during which their benefits were payable ended.

The design of the health credit for displaced worker reflects the President's goals of providing targeted, quick assistance to Americans who have lost their jobs in the recession. Because the proposal builds on the existing infrastructure of programs to assist displaced workers, and because it strengthens all of the coverage options available to displaced workers now, it can be fully implemented in a matter of a few months. In particular, state workforce agencies will certify eligibility for the health insurance credit when they certify that a displaced worker is eligible for unemployment insurance benefits. Almost all unemployed workers who lose their job involuntarily are eligible for unemployment insurance, at least initially. The Administration also supports emergency grants to states to enable them to quickly provide additional health insurance assistance, without the need for state legislative action. Displaced workers can claim an advance credit at the time of purchasing health insurance coverage by providing their insurer their certification along with the remainder of the premium. The insurer will be reimbursed by the U.S. Treasury for the amount of advance credits it provides.

We believe the displaced worker credit offers a number of advantages over competing proposals that limit tax credits or subsidies to COBRA-only policies. Medicaid expansion is also not an ideal way to provide quick and efficient replacement insurance to the affected individuals.

A COBRA-only credit would provide no benefit to 40 to 50 percent of displaced workers with health insurance, because they work for small firms not covered by COBRA or they purchase non-employer policies. The alternative of forcing workers not covered by COBRA into a State Medicaid plan would require these workers to drop their current insurance coverage and possibly change health care providers if they do not participate in Medicaid. Extending Medicaid to cover these displaced workers would require State legislation, and would necessitate delays before State legislatures were even in session to address this issue. Many States have made clear that, because of tight budgets, they cannot afford such unprecedented expansions beyond their core target populations anyway. Moreover, such expansions would take away resources from their ability to fund better coverage for their priority populations: low-income children, families, and seniors.

In addition, a COBRA-credit would impose a costly new mandate that employers would be required to implement immediately. The mandates are most burdensome on smaller firms and those that have had significant layoffs—precisely the firms that need the most help now to prevent further job losses. Further, a COBRA-credit is poorly targeted to workers who lose their jobs because of the economic downturn. At least 60 percent of those eligible for the COBRA-credit are workers who voluntarily leave their job, not displaced workers. According to independent estimates, twice as many workers who have lost their jobs in the recession would be helped by the health credit for displaced workers than by a COBRA credit or subsidy.

As a result, for a similar budgetary cost (and at no budgetary cost to States), the health insurance credit for displaced workers would be available for a longer period of time, would be more efficiently targeted, would offer workers a greater choice among health insurance plans, and would not weaken employer incentives to continue to provide health insurance to their workers. The credit would also reduce adverse selection in both the employer market (because more healthy workers would choose to remain in COBRA coverage) and in the individual market (because many people who otherwise would have gone without health insurance will purchase coverage).

Conclusion

The absence of health insurance coverage for some 40 million Americans is a problem calling for immediate solutions. The President's Budget sets forth a package of solutions, including most importantly a proposal for the use of tax credits to offset the cost of obtaining health insurance that has received broad bipartisan support. If enacted, this proposal can lead to a significant reduction in the uninsured population and at the same time lead to improvements in the market for individually purchased health insurance, greater choice and flexibility for individuals in determining the coverage that best fits their needs, and improvements in the quality and price of health care provided to all Americans. This Administration desires to work closely with Congress, in a bipartisan manner, to make this vision a reality.

Chairman THOMAS. Thank both of you very much, and I do compliment the Administration in moving the dollar amount on the credit from $2,000 to $3,000. I do find it ironic, though, that that

dollar amount is in competition with an unlimited amount which requires no prioritizing whatsoever under the more traditional fringe benefit structure, but you are moving in the right direction.

Second, I also want to compliment you on the flexibility that you have begun to add. The idea that we would limit the way in which the credit would be used is, I think, a valid criticism, and once again you have at least moved in responding to that concern.

Statements were made in opening remarks, and others will make the statement that this is modest, it certainly doesn't cover that many folk. It seems as though if you don't have a solution for 40 million uninsured, you don't have a solution at all. Does the Administration have some numbers which indicate the number of uninsured that would be covered under this particular proposal, and if so, would you wish to present them to us?

Mr. WEINBERGER. Yes. The numbers for the health insurance tax credit, our estimates are that 15.5 million would receive the credit. Six million of these individuals would have been uninsured for at least part of the year, and about 10 percent of the individuals taking the credit would otherwise have received employer-provided health insurance.

Mr. MCCLELLAN. So just to be clear, the vast majority of people who are covered under this credit now are either uninsured, that is 6 million, or not getting any assistance at all for purchasing nongroup health insurance, and so they will be able to afford better coverage. And the impact on the 160 million employer market is negligible.

Chairman THOMAS. I thank you. The gentleman from New York wish to inquire?

Mr. RANGEL. Thank you. I want to thank both of you for your testimony. Mr. Weinberger, your opening statement was laced with remarks about bipartisanship and working together, and I wondered whether you know what Committee you were testifying in front of, because you have had a very limited experience of bipartisanship with this Committee.

And it would seem to me that if these are the hopes and aspirations that you would like to see, that you in the Administration will have to dramatically do something in order to achieve these goals. It would seem to me that for openers you might consider having meetings with Democrats, people in the minority, and sharing these views, rather than having us come to hearings and finding out that the majority and the Administration have made up their minds as to what the health care should be.

This is especially so when I know that you know that many people, including our leader, some that are very close to me physically if not politically, have claimed that one of their targets is the employer-based health care system, as opposed to expanding health care generally. Well, I am not opposed to people having political goals, but sometimes they interfere with bipartisanship, which I assume you can understand. And if indeed some of us are paranoid in believing that you are against employer plans and unions more than you would be for health coverage, that is something that should be discussed with honest people who have honest disagreements.

But I would suggest to you if you are serious about this goal of bipartisanship, especially in an election year, we need outside help, and I hope you would consider deciding how you intend to bring about this goal, because I think that both parties can benefit in working together. There is enough to fight about in November, but health care should not be the subject of a partisan debate.

So I thank you for coming here, and you, Mr. McClellan, and let me see where we go from here.

Chairman THOMAS. I thank the gentleman. The gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Mr. Chairman.

First of all, I think it is very important that you have developed a better mechanism of delivering a tax credit, and I think that I don't want that to be missed in this debate. For those of us who have long been interested in a tax credit as a means of reaching those who couldn't afford the premiums for health insurance, that issue of being able to deliver the credit in a way that doesn't require people to carry the cost until the end of the year and then deduct it, and to be able to deliver it to people who don't pay enough taxes to ever get the credit back, is very important.

And could you describe for the Committee a little bit as to how that mechanism works, and as importantly, whether it would work as well if we used that mechanism for all the uninsured as opposed to just the unemployed uninsured?

Mr. WEINBERGER. A clarification. Is your question with regard to the displaced worker credit or the health insurance credit, or both?

Mrs. JOHNSON OF CONNECTICUT. Well, are you using the same mechanism Mr. McClellan mentioned, that the uninsured credit is also advanceable and refundable?

Mr. MCCLELLAN. Right.

Mrs. JOHNSON OF CONNECTICUT. So if you are using the same mechanism in both instances, you need to talk a little bit more about the mechanism and why it would work with the larger group of the uninsured as well as with the smaller group. Because with the smaller group, when you are unemployed you go for unemployment benefits, so at that time you can also get the credit power.

Mr. MCCLELLAN. Right. Just to respond to the question about mechanisms, I want to talk about both the displaced worker credit mechanism and the health insurance credit mechanism, because they are not the same.

From the standpoint of the user of the credit, though, they both have a similar effect. You can write your premium check for the portion of the health insurance cost that is not covered by the credit only, so when you are signing up for insurance, it is much cheaper. It is cheaper by the amount of the credit. You get it in advance.

The actual mechanics for doing it are a little bit different for the two credits. For the displaced worker credit, the quickest way to identify the people who need help and to get help to them is to build on the strong existing infrastructure of unemployment benefits. That credit would be available through State and local work force offices, which is the first stop that people usually make when

they lose their jobs, to find out about the income benefits available to them, the training opportunities, the job search opportunities and so forth.

Under our credit proposal, people would qualify for the health insurance credit as soon as they qualify for unemployment insurance benefits. It is that simple. They would receive a number that they could write on their check, and they would send in the check for their portion of the premium, and the insurance company would get reimbursed directly from the government for the remainder, for the amount of the credit.

For the health insurance credit, that is a credit that's value depends on income, so what is key there is a person's or a family's income in the prior year. At the end of the year when you file your taxes, you know how much money you had in that year. You let the Internal Revenue Service (IRS) know that, and the IRS will notify you or get you the information on how much of a credit you qualify for. And then once again you just write a check for the portion of the premium that you owe. The credit is paid directly to the insurer, so that you don't have to pay as much out of pocket for health insurance.

Both of these mechanisms can be implemented very quickly. The displaced worker credit we think we can have operational within a few months of passage, and people in the meantime would have the confidence of knowing that they are going to get 60 percent of their health care costs covered. The health insurance credit would be up and running next year.

Mrs. JOHNSON OF CONNECTICUT. One of the reasons I think it is so important to move forward in the stimulus bill on this issue is that we can then pilot that mechanism. But I would hope that Members on both sides of the aisle would not allow the issue of who talks to who to interfere with all of us talking together to take advantage of this opportunity to have in the budget money for the uninsured, and work on a mechanism and try it.

It is not going to be the sole solution, but we have all known, both sides of the aisle, it was a critical component. And we have a chance to move forward on that this year, and I hope anyone who is really interested will let us know and be part of the solution.

Thanks. My time I think has expired.

Chairman THOMAS. I thank the gentlewoman. The gentleman from California, Mr. Stark, wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. Mr. McClellan, have you read Professor Gruber's testimony?

Mr. MCCLELLAN. No, sir, I have not had a chance to read his testimony in full for today, but I have seen it and I am familiar with the main points in it.

Mr. STARK. If you could, if you wouldn't mind answering this just with a note if you have, but he is suggesting that about 4 million people would leave employer-based coverage and that—I mean, he doesn't agree with your numbers. He says that health tax credits would reduce the number of uninsured by about 2 million. And economists can differ, and I would just like to know where your research differs from his.

Ken Thorpe at Emory suggests that under this plan, the Federal cost for a newly insured person would be around $4,100, expanding

the State Children's Health Insurance Program (SCHIP) would run to $2,300. So there is some difference here as to how many people would be in and how many would be out, and my guess is that a little more empirical work would get there.

The line that I would like to follow with you guys is this: that there is no guarantee that there wouldn't be medical underwriting, right? And that is in the interest of the insurance company. There is nothing in this proposal to get the insurance companies to take people with any kind of preexisting condition, and they are pretty fussy about that. Bad back, a whole host of things, and those things are eliminated.

The chart that we got from eHealthInsurance.com, from whom we will hear later, in trying to get the lowest policy available in each community for Members of the Committee, in round figures only Seattle got below $2,900 approximately for a premium. So what is out there today, lowest, now, for a family of four is about $3,000. For us in the Federal Employees Benefit system it is about $7,000 for the generous Blue Cross high option, which is in my opinion a pretty good policy.

So there is no way that a $3,000 tax credit, which really drops to $1,700 for a family of four in the $40,000 income bracket, so we are not talking about $3,000 tax credit for a lot of people. And then all of these policies that I have on my list have between $1,000 and $2,000, most of them have $2,000, in Minnetonka it is a $6,000 deductible. What is in the water up there? But what I am—and many of them, 10 of them have no maternity benefits, five of them don't have a prescription drug benefit, two of them don't even cover emergency room.

So I guess what I am getting at is that if we are going to cover people, the credit isn't adequate. Now, you can argue all over the place, but I would challenge you, either of you, and then I would stand corrected, shop for me in the market, in the individual market. You can get the rates. You can probably get them faster than I can.

And show me in various communities what these people can get, because you really are talking about tax credits of $1,700, with two adults and one child, $1,400, one adult is $600. You aren't going to find much in the market that really covers people if they are not going to have to come up with $2,000 or $3,000 more, and if they lose their employer-based insurance, if that is correct, we haven't done much to help people.

I have no quarrel with giving a tax credit, but there is another side to this. You have got to make the product available. And my question is, would the Administration support controls on the private insurance market to make sure that these policies are available? What do you suspect, Mr. McClellan?

Mr. MCCLELLAN. The Administration certainly supports additional steps to help private insurance markets make this available——

Mr. STARK. But I said controls on the insurance industry, which would mean community rating or universal coverage non-underwriter. Would you support those sorts of controls to make these products available at a reasonable cost?

Mr. MCCLELLAN. Our preference is to support the additional steps that will actually make more affordable insurance available to a wider number of people. I think the experience of States that have tried community rating coupled with guaranteed issue requirements has been that the resulting price of premiums available in the nongroup market is significantly higher, significantly higher not only than policies for relatively healthy people in other States, but significantly higher than policies in high-risk pools or other options that are available in other States.

But I certainly would like to work with you and your staff on finding ways to reach the goal of making affordable health care coverage options available to everyone. We just think that there are probably some better ways to do it than restricting access to coverage.

Mr. STARK. In Texas, for instance, a 55-year-old male smoker would pay $13,000 in the State's high-risk pool. You know, what good is this tax credit going to do that person? You could tell him to quit smoking. I would join with you in that.

But my point is that high-risk for different insurance companies means a lot of different things, and there is no way that I can see that we can really say to the public we are giving them access to decent medical care at a price they can afford. Because when you add the deductibles and the other things that they will be out of pocket in the current market, without some controls on that market, you don't have a plan. And I would like to be proven wrong.

Mr. MCCLELLAN. Sure, sure. Well, to help address your concern, the Council of Economic Advisers did a study of policy availability in all 50 States, looking at multiple communities within each State, and that is included in the CEA document that you have available to you.

These policies were not first dollar policies. They were typically preferred provider organization (PPO) plans that had preventive care coverage, maybe emergency care coverage, and they did have significant deductibles, but they gave people the option of going outside of network, getting rid of the managed care red tape, getting whatever treatments they thought were best for them, while still providing good catastrophic protection.

In addition, there are also some reasonably priced network plans available that have much lower out-of-pocket payments——

Mr. STARK. That is good, Mr. McClellan—if I could just finish, Mr. Chairman—for you and me. You are making more than $100,000. So am I. But I am talking about the family with two adults and two kids making $40,000. They don't have anything left for this high out-of-pocket. They get $1,700. And those are the people that we are not helping.

Mr. MCCLELLAN. Under our proposal, low-income families would generally get access to coverage that was, for the plans that we looked at, the average premium for a plan of this type was less than $3,000, less than $1,000 for young individuals. Family coverage similarly had more than 50 percent subsidies available.

Mr. STARK. How much deductible, though, on top of the premium?

Mr. MCCLELLAN. Well, at most $1,000, if you buy an open PPO plan. If you prefer a network plan with lower co-pays and smaller

deductibles, you can have more coordinated care at a lower out-of-pocket cost.

Mr. STARK. You make my point. One more time. You make my point. $3,000 to buy the policy. You give them $1,700, so they are out $1,300 and another $1,000 to $2,000 deductible, and still——

Mr. MCCLELLAN. I think the bottom line here is that we end up getting 6 million more people covered who wouldn't have been covered otherwise. So go back to Dr. Gruber's analysis, and I have worked closely with Jon on many issues. His study, it looks like it is an analysis like one he did a year ago of a previous proposal that was even a little bit different from ours then. It had different income limits. It examined a very rich first dollar plan, which is not what we are aiming to provide affordable coverage.

Mr. STARK. It is this proposal that he——

Mr. MCCLELLAN. It did not address advanceability and other issues to a significant degree. I am just saying his estimate, that he says is of this proposal, is very similar to his estimate of the previous proposal last year, which does not address issues such as the availability of lower-cost plans which are widely available; the income limits in our proposal; the effective advanceability mechanism in our proposal; the fact that some people want to get coverage for part of the year, not just the entire year. None of these things are covered in his model.

And I put a lot of faith in the Treasury staff estimates of this kind of analysis. They have done very accurate and effective and comprehensive work on a very detailed model that has been in existence for many years and picks up a lot of subtleties in markets that are very hard. You know, I come from an academic perspective, too, and we try to do our best, but often we are working alone, without a dedicated professional staff.

So I put a lot of faith in those estimates, and beyond that, in terms of crowd-out estimates, I just would point out that Dr. Gruber's research also shows that whatever you do for the uninsured, you need to be very careful about affecting employer coverage. For example, his research on Medicaid expansions indicates that over 50 percent of the new coverage is people who would have been covered elsewhere.

Mr. MCDERMOTT. Mr. Chairman——

Chairman THOMAS. I would make a request both of Members and of the witnesses that the gentleman's 5 minutes became 9 minutes and 40 seconds. However——

Mr. MCDERMOTT. Mr. Chairman, could we have the numbers that he has? I don't know if they are available. He said he has a set of numbers there that some of us haven't gotten copies of.

Chairman THOMAS. If the gentleman has numbers and wishes to share them——

Mr. MCCLELLAN. There is a CEA analysis that should be on the table with the other documents for the hearing, and the——

Chairman THOMAS. If the gentleman's staff would distribute the numbers. Last week it was charts, this week it is numbers. I do believe it is important that everyone have the material that we are discussing.

And the Chair wants to make a point that one of the reasons the Chair allowed the gentleman from California the additional 4 min-

utes was because the questions he was asking were important, and there was a line of questioning that he wished to pursue.

However, the Chair wants to make it clear that if in fact the tax credit has some impact on the employer-based system, any other modifications would also have impact on the employer-based system, and I believe Professor Gruber shows that modifications in a significant fashion on Medicaid would have a negative impact on the employer-based system. So if we are going to make a point, we need to make it on a broad basis, that any enhancement of any other program would obviously result in a modest negative impact.

Also, we have to remember that we are not dealing with health insurance in a vacuum and that the Federal level is the one to make all of the changes, because frankly it is primarily a State-based question, and there are a number of States—this has guaranteed issue—there are a number of regulations at the State level that require adjustment.

But the final point that the gentleman made I think is an excellent one. I talked about the fact that we moved from $2,000 to $3,000. That is a move in the right direction. I also underscored the fact that the employer-based system is open-ended. One of the problems in this system, the Chair believes, is not that we are not spending enough money on health insurance, it is that it is maldistributed under the current structure.

And if the gentleman wishes to enter into a discussion of capping the employer-based system at a reasonable amount and redistributing that to require this one to be slightly larger, a redistribution of the current tax benefits for health insurance, I think you will find we can move rapidly to a much more handsome program for those who now get nothing under the system. The gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes, Mr. Chairman, very briefly.

You know, purchasing insurance—I would like to address this to Mr. McClellan if I could—purchasing insurance in the open market, as you know, is not easy. You know, many are denied coverage, restricted benefits, things like that. So I guess the question I have is, will adding a large tax subsidy and increasing the size of the individual market change any of this? In other words, will the cost go down?

Mr. MCCLELLAN. Yes, sir, it should help significantly with the costs of coverage available in the insurance markets generally. We have some analysis of this in the CEA study that I mentioned. The simple idea is that if you give people subsidies, those who are healthier and not participating in the insurance markets now would begin to do so. That improves the risk pool available for everyone and reduces the costs of coverage available.

In addition, all of the people who are already purchasing in the individual market, as I mentioned, there are 16 million of them today, would generally have access to more affordable coverage as well. They would be willing to buy more generous plans than they have now in the case when they receive no subsidy at all.

We provide big subsidies for employer coverage. We are starting to provide subsidies for the self-employed. But this group gets none of those subsidies, and that is one reason their benefit packages

tend to be less. By providing a new subsidy, we move this entire market in the direction of more generous, affordable coverage.

Mr. HOUGHTON. Thanks. That helps. Thank you.

Chairman THOMAS. The gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I sure hope that we can have a discussion about this tax credit business and not get the volume up too high. Mr. McCrery and I, like Mr. Stark and Mr. Armey, spent a lot of time talking about this. And certainly if you believe that private sector answers are the way to go, tax credits, you have got to look at them, one way or another. I happen to be somebody who believes that ultimately the government will provide the whole thing, but that is—we are getting to that.

But when we were looking at this, and we couldn't figure out any way to do it without using community rating, now I don't think there is anybody in this room—there might be somebody so out of touch that they would think the insurance industry is going to let us or encourage us or be supportive of us going to community rating and demanding that, so that the individual market is anywhere reasonably available. I just want to take an example that I know.

Boeing is in the middle of laying off about 30,000 people at the moment. These are aerospace mechanics who make somewhere between $40,000 and $60,000, depending on unemployment. They have a policy that is worth $7,000 under their COBRA, so if they want to go out and buy a COBRA policy, they have $7,000 to come up with. Unemployment benefits in Washington State, as in Massachusetts, are the best in the country, $450 a week. That means you get $1,800 a month to live on, and you are looking at a premium of about $600 to pay for your insurance.

Now, that is the maximum. If you are from Mississippi, the average unemployment benefit is $190 a week. That means $800 a month to live on. And it is—I cannot see how you—I mean, that is what I said once in this Committee. I don't know if anybody has ever been unemployed.

When you have rent—we had a hearing in Seattle about 2 weeks ago, and a woman who was laid off, working for the Westin Hotel, is living on—she is living on the minimum benefit, which is around $800 or $900 a month in Washington. Her rent is $510 a month. Now, she is raising two daughters on $800 a month, or trying to, on that unemployment. And interestingly enough, if she works three shifts at the hotel, she gets insurance. If she works two shifts, she doesn't get insurance. So everybody is now working two shifts a week, if they are working at all.

And when you take a benefit of $1,000 a month or whatever you might say, and then talk about a reasonable place to live, no subsidized housing, so you are now spending, in her case more than half her unemployment check goes for her rent. And I said to her, "Well, how much do you spend on food?" And she said, "Well, I spend $100." I said, "$100 a month?" And she laughed and said, "No, no, no. $100 a week for the three of us."

So now you have got $400 of food. Well, maybe you can cut that back. Maybe $50 a week, right? But there is no economic way you can make this possible for people, even if you give them all the

money up front, if you are talking about $3,000. Now, Jim and I never could quite figure out what the figure was, or what percentage you had to subsidize, but this in my view does not work for unemployed people.

And most of the uninsured people are not making more than $6 or $7 an hour. Most of them are somewhere around $25,000. They are not, they are also not in much of a position to go out and buy in the individual market. They don't even have the—well, COBRA is really no advantage, because you get jumped up in how much you get.

How did you pick $3,000? That is my question. Was that a number backed in to how many people you think are going to use it?

Mr. MCCLELLAN. The $3,000 figure for our health insurance——

Chairman THOMAS. The gentleman's time has expired. If the gentleman will respond briefly to the question.

Mr. MCCLELLAN. Yes. The $3,000 maximum figure for the health insurance credit was done to balance the need to give access to affordable policies for lower-income families with a desire not to have too generous of a subsidy and disrupt employer coverage. That did it. That led to a very large number of people getting coverage.

And I just would also add that we also support, as part of the economic stimulus legislation, assistance for workers who have lost their jobs to cover 60 percent of their health care costs, along with other benefits like emergency grants to provide additional assistance, and no cap on those benefits.

Chairman THOMAS. The gentleman's time has expired. The gentleman from California, Mr. Herger, wish to inquire?

Mr. HERGER. Yes. Thank you very much, Mr. Chairman.

Mr. McClellan, I have several. I want to continue on this same line of questioning, but I want to allow you plenty of time to respond, if I could. As we are hearing, there are some that are concerned that the tax credits would not work because they believe it is so difficult to get insurance on an individual basis. A series of questions, if you could.

Are those criticisms valid? And how does the President's proposal address these issues? And, finally, are the policies in the individual market affordable?

Mr. MCCLELLAN. Very good questions. Thank you, sir.

The President's proposal includes a number of elements to make sure that virtually everyone has access to affordable policies. As I mentioned, we did a comprehensive analysis of all 50 States to examine the actual premiums available to people who are purchasing in the nongroup, the individual market. And, again, for the vast majority of people, the vast majority of low-income families would get 50 percent or more subsidy for the cost of their health insurance. And according to many academic studies, that level of subsidies is substantial enough to induce and allow most of them, to buy coverage.

Beyond that, we also include a number of other elements to help workers or individuals who may need additional help with the costs of their health insurance. We allow the credits to be used in high-risk pools which, as Chairman Stark mentioned, in some States

have very high premiums, but in many States where they are well-funded, broadly based, Minnesota and others, there is good coverage available for not much more than the cost of a general premium, certainly for much less than the cost of a community rating requirement State's policy.

In addition, we also support the use of these credits in purchasing groups that States could set up. States often have the infrastructure in place through competitive approaches that they are taking in their Medicaid and SCHIP programs to do this, or through the employer plans that they have available to their own employees, another option for getting affordable coverage to people who may not have the best options available in the individual market.

Altogether, we think this is a robust approach to making affordable coverage available to everyone who is now purchasing or has no other option besides purchasing in the individual insurance market. We need to make those options for those Americans much better, since people who are not offered employer coverage and since low-income people who are not eligible for public insurance have the highest uninsurance rates in the country.

Mr. HERGER. Thank you very much, and I think that is the crux of what we are trying to do. We are attempting to help those who are currently unable to have health insurance be able to acquire health insurance. And I want to thank you and the Administration for, I believe, making a major step forward in attempting to do this.

And I believe at the same time when we have—the more individuals we have out shopping around, I think that helps bring the prices down. It brings about more competition. So I think there is a number of side pluses that we have, as well as what you are doing. I commend you and I commend the Administration.

I yield back the remainder of my time, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. The Chair wishes to note that there obviously are a number of Members engaged in the debate going on on the floor, and they may not be able to be here for a presentation of questions. They do, however, have questions, and Members can always submit those questions in writing. We will make sure they are available to you, and we would appreciate a prompt response to those questions that are submitted in writing.

The gentleman from Wisconsin, Mr. Kleczka, wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

A quick question of Mr. McClellan. Mr. McClellan, in your estimation, will the Administration proposal serve to strengthen or to diminish employer-sponsored health plans?

Mr. MCCLELLAN. The Administration's package of health care proposals will strengthen the employer market. As I mentioned, this particular proposal——

Mr. KLECZKA. In what manner? How?

Mr. MCCLELLAN. The particular proposal we are discussing now is going to provide good options to people who do not have employer coverage. In addition, the Administration's budget also supports a number of proposals to strengthen employer coverage.

For large employers, that are already offering a range of choices, we want to make it easier for people who are choosing plans that require significant out-of-pocket payments to meet those payments. We want to give them tax-free options for paying out-of-pocket costs, through rollovers of flexible spending accounts and through broader availability of——

Mr. KLECZKA. Now, that is a totally inadequate answer. Let me address, Mr. Chairman, the audience, the people watching us on FAT NET, and that is the second camera over there. This is not an issue that we usually talk in this Committee, like alternative minimum tax (AMT) for businesses, right? And you can sit there and listen to that, and you folks over here can sit and write that, but that is for the next guy.

This is an issue which directly affects everyone in this room and viewing this hearing who has employer-sponsored health insurance. And that is the plan where we are in a group, there are sick people, there are healthy people, there are young people, there are old people, and the employer says, "Okay, you pay 20 percent of the premium, I'll pay the balance."

And that is the plan that about 177 million Americans have. It is a system that works. But we are being told today that we are going to replace that system, and you are going to hear comments, "No, we're not. We're just taking care of the uninsured." That is baloney. That is nonsense.

And I refer you to the comments of our esteemed Chairman, who indicated on December 14th that the current employer-based health care system is fatally flawed. Okay? He thinks it is broke. I have got employer-sponsored health care insurance. Works fine. Okay?

The other comment that you should write about, folks, is that Mr. Thomas will offer a bill this year to jettison the entire employer-sponsored health care system. That is what this is all about today. And do you realize what a boon it would be to the employers if they didn't have to pay your 80 percent health insurance premium?

If you thought the AMT, repealing the alternative minimum tax for companies was bad, and making that retroactive, having the effect of giving IBM a check for $1.4 billion, if you thought that was bad, take a real close look at this one, because this is better for the employers than that measly check. And what is going to happen to you folks? You are going to go on an individual basis to an insurance company and try to get coverage, versus the group plan where, again, you have sick, healthy, young, old.

Now it is you alone. And just like in the National Basketball Association during halftime, they have this game called "one-on-one," that is what we are doing. It is one-on-one, the insurance company and you and your family. And who do you think is going to win that battle?

Let's look at the premiums being offered by eHealthInsurance.com, and they will be testifying later, for the city that I hail from, Milwaukee, Wisconsin. All right. On average, the annual premium is going to be $3,000. The deductible is $1,000, so now that is $4,000.

And what is covered? Maternity, optional. Prescription drugs, many of you have it in this room, not covered. Health insurance is for when you get sick, when you have an emergency. This policy being sold in Milwaukee, Wisconsin, does not cover the emergency room, one of the reasons you have it in the first place. And office visits, you have got a sick kid, you want to take them to see the doc, or yourself, you are not feeling well, office visits aren't covered.

So know full well what we are doing today is not trying to cover some folks in this country who are uninsured, because the reason they are uninsured is, their employer don't offer it, if they are working, or they can't afford it. Based on the e-plans that we are sharing with you today, they are still not going to be able to afford it.

And if you are unemployed and you are not able to have the government help you with some COBRA coverage, after your rent or your mortgage payment, your car and your bills and your food and your clothes for your kids, there ain't no money left in that unemployment check for health care coverage.

So what we are doing today, my friends, is sounding the death knell for employer-sponsored health insurance, and make no mistake about it.

Chairman THOMAS. The gentleman indicated that the Chair held certain positions, and then represented what those positions were. I think those that he appealed to, both visually and in the written media, need to understand what it was that he was saying.

He said the Chair believes that the employer-based health system form of insurance is fatally flawed. The fatal flaw is that it doesn't cover everyone. The only people it covers are those that are employed. And if you were going to build a system, which we are now looking at, the "uninsured," we are trying to deal with those who now do not have an employer-based system. If we got everyone health insurance through their employer, it still would be flawed because there are some folks who don't work.

Mr. KLECZKA. Will the Chairman yield?

Chairman THOMAS. No. The flaw is that the system is not a basis that can provide universal coverage.

Second, the gentleman said that you have a group plan with an employer and an individual market if you don't. Who today, in trying to build a plan for all Americans, would say that we will allow those who are able to get up and go to work every day, carry out functions at the work place, the healthiest Americans get the cheapest price for their insurance? But those who are not able to get up every day and work have to pay the highest price for their insurance. No one would build a plan like that.

If we were to propose that the group plan, the lowest rate would go to the healthiest Americans today, we would be absolutely opposed to that concept. Any economist will tell you that when you look at wages and fringe benefits, they are totally related. The more fringe benefits, the less in wages; the more in wages, the less in fringe benefits.

Mr. KLECZKA. Will the Chairman yield?

Chairman THOMAS. It all comes out of the employee's pocket, and that at some point——

Mr. KLECZKA. Will the Chairman respond to the quote that he is going to jettison the entire——

Chairman THOMAS. At some point employees need to realize that the benefits they are getting come out of their pocket, and that at some point an educated consumer perhaps would like to make slightly different judgments for themselves on health insurance, if it were available, than the employer makes for them.

Those are the points I would like you also to include as you examine the system. What we are talking about here is a modest attempt to augment a flawed system. It immediately gets escalated to blowing up the employer-based system. I find it ironic that when we try to reach out, the response is not a different or better idea, it is once again fearmongering in terms of hanging onto a system——

Mr. KLECZKA. Mr. Chairman, I object to that.

Chairman THOMAS. That was and is fatally flawed.

Mr. KLECZKA. Mr. Chairman. Mr. Chairman, a point of order.

Chairman THOMAS. The gentleman's time has expired. The gentleman from Louisiana wish to inquire?

Mr. KLECZKA. There is no fearmongering here. I am basing my comments, Mr. Chairman, on your statements. And you didn't respond in your last set of remarks to your comment about jettisoning the entire employer-based system,

Chairman THOMAS. The gentleman is out of order.

Mr. KLECZKA. That is what I am talking about. If that is fearmongering, then you were misquoted or you misstated your point.

Chairman THOMAS. The gentleman is out of order. His time has expired. The gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes, Mr. Chairman. I am going to begin my remarks, and I may have a question, I may not, but I am going to begin my remarks on a positive note and end my remarks on a positive note. I can't guarantee the substance in between.

But I commend the Administration for your efforts to address the problem of the uninsured in this country. I do think that the problem of the uninsured is regrettable because of the lives of people who are damaged by their lack of health insurance. I think it is also regrettable because I think it is one of the things driving us toward a single-payer system. It is one of the things driving us toward a movement for the government to take care of everybody in terms of their health care.

And Mr. Kleczka, I guess he has left, but he tries to set this up as a battle between the employer-provided health insurance advocates and those who want an individual market. I believe it is a much bigger and more important battle than that. I believe it is a battle between those who want a single-payer system, they want the government to provide health insurance basically for everybody, and those of us who believe in a private market for the delivery of health care in this country.

Both views are legitimate, and those who hold the views are good Americans and they want to do what is best, I believe. Jim McDermott is one of those, Pete Stark is another, who believes in the single-payer system, and most countries in the world have some sort of single-payer system, so who is to say that they are

wrong and I am right. I believe we in the United States can find a better way to do it, to provide a better quality of health care for everybody than Great Britain or any number, Canada, other countries that have a single-payer system.

But I believe that is the battle, and the thing that I find troublesome about the Administration's proposal is that it is a toe in the water. You are just going a little ways to solve the problem of the uninsured, and you are using tax credits to do it, and I believe it will fail. Yes, it will provide coverage for a few more people, but the whole concept of tax credits and the individual market will fail, and that will add fuel to the fire for a single-payer system.

So I would like a much more ambitious program. Yes, I am one who thinks that the employer system is flawed and we ought to go, big time, from employer-provided health insurance to individually owned and provided health insurance. I think that is probably the only way we are going to avoid a single-payer system. But if we go just a little ways and we don't do insurance market reforms to make sure that the individuals have access to insurance, if we don't do reforms in terms of either government-mandated or government-provided information to the consumer so that they can make educated, informed choices for their health insurance, then we will fail, and the only outcome will be for the government to take over the program.

So I am unabashed in my support of going toward an individual-based system and away from an employer-based system, and make no apologies about it. I am afraid, though, that what the Administration has proposed is too little. However, I commend you for trying.

Mr. MCDERMOTT. Mr. McCrery, would you yield to a question?

Mr. MCCRERY. Sure.

Mr. MCDERMOTT. I have some analysis by M.I.T., the Massachusetts Institute of Technology, and the Kaiser Foundation that says that under the tax credit proposal, more than two-thirds of those using the tax credit would be people who are already insured. Is that——

Mr. MCCRERY. I have no idea, but reclaiming my time, the biggest threat, I would say to Mr. Kleczka, to the employer system, employer-provided health insurance system, is cost. Cost.

As cost continues to go up, and we are getting double-digit increases this year in employer-provided health insurance, as those costs continue to spiral upwards, you are going to have fewer and fewer employers choose to provide health insurance to their employees. And it is a choice. There is no government mandate. They don't have to do it, and as costs continue to go up, fewer employers will provide it and the employees will have to pay more and more of the costs for that health insurance. That is the threat to the employer-provided health insurance system.

So what are we doing about cost? In this proposal, not much. Mr. McClellan has talked about, well, it should bring down premiums because you are going to give them these good risks in the system. I think that is a bunch of baloney. You are not going to get enough of them in the system to do much good overall on premiums.

And my time has expired, and I could say a lot more. I need about another 20 minutes or so. But, Mr. Chairman, with that I

will—and I wanted to end on a positive note. I do commend the President for——

Chairman THOMAS. The Chair thanks the gentleman. Others don't feel constrained in that way. I appreciate the gentleman, but others haven't felt constrained in that way. The Chair hates to disrupt someone on a roll.

Mr. MCCRERY. I thank the Chairman for his consideration, but in view of the few number of people who are here, I will wait perhaps for a second round. Thank you.

Chairman THOMAS. The gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman, and thank you both for your appearance here today and the work you are doing on this important problem.

We all know the statistics: 39 million Americans, or more, who don't have health insurance, 8 million of the uninsured being children. As Mr. McCrery just stated, an 11-percent increase in health insurance premiums. This really comes home to me when I go back to Minnesota every weekend.

I know too many people in Minnesota who are unemployed because of the Bin Laden recession. I know too many families who are hurting. I know too many adults and children without health insurance in Minnesota, and they live in fear, true fear; fear of getting sick, serious illness; fear of getting injured and not having health insurance. These people live in real fear, and they express these feelings to me only too often.

So I applaud the Administration, the President, those of you who are working with him in the Administration to address this problem. We have let it linger too long, the problem of displaced workers and the uninsured.

The proposal that we are talking about today, one of the positive, very positive aspects I believe is the fact that it is a large umbrella. If you lose your job, you are still unemployed, you are covered. You don't lose your health insurance. Certainly Medicaid is not the answer. Forcing millions onto welfare would only discourage the unemployed from working and threaten welfare reform.

I want to ask you—and again picking up where the gentleman from Louisiana left off, because I share his concerns—I certainly understand and agree with the concept of refundable tax credits in the way you are proposing it, the way we have tried to advance it here on the Committee. What about, to answer some of the criticisms affecting those people who are indigent, what about doing what the first Bush Administration did, not only including refundable tax credits but also vouchers for the uninsured who are indigent?

Mr. MCCLELLAN. Good question, Congressman. Just to highlight that many people who are low income or have limited means would be helped by our health credit proposals. The proposal for displaced workers would give immediate assistance to the families that you mention that you are seeing back in your district, who have lost their jobs and are struggling to continue their health insurance or having to go without it.

All of them, all of them who have lost their jobs involuntarily would be eligible for our displaced worker credit. In addition, peo-

ple who have low incomes would be eligible for up to $1,000 for each individual and $3,000 per family under our health credit proposal.

Beyond these proposals, the President also has supported strengthening every other aspect of our health care system. It is not a one-size-fits-all health care system.

Mr. RAMSTAD. Pardon me. Just to interject, just to digress, so that means people with no tax liability whatsoever——

Mr. MCCLELLAN. Absolutely, would get the full amount of the assistance, so people——

Mr. RAMSTAD. Which is tantamount to a voucher.

Mr. MCCLELLAN. I don't know if I would call it that, because we are planning on having them, you know, just send in a check for their portion of the premium, but it amounts to a direct payment for a large part of their health insurance costs.

Mr. WEINBERGER. Can I just add, Congressman Ramstad, the way that it is structured with the advanceability gives real-time money so that these individuals when they go pay their premiums will get a subsidy amount that they will include with the premium payment, so they will pay a lower cost for those premiums. So that is advanceable. If they don't want to take it that way or for some reason they would also like to take it on their tax return, they are also allowed to do it that way.

Mr. RAMSTAD. Well, I think this makes eminently good sense. The other element of the plan that is very appealing, the flexible spending accounts, the FSAs, I think again a very, very useful way to approach this problem. Could you just briefly elaborate on the FSAs? I think it is important to explain.

Mr. MCCLELLAN. Sure. The flexible spending accounts basically allow individuals to roll over $500 or to take that $500 out. The purpose of doing that, of course, is currently a "use it or lose it" plan. So at the end of the year you find individuals making some expenditures they might not otherwise want to make or need to make, in order to use up that money in the account.

And so we give them the ability to roll this de minimis amount over into a future year. It also, we hope, will increase the take-up rate, because then people don't have to try and target the amount that they want to put in these flexible spending accounts to the exact dollar that they otherwise would expect to spend.

Mr. RAMSTAD. Well, thank you very much. Just a final brief comment. You know, some of the hyperventilating notwithstanding here today, I truly hope we can work in a bipartisan, pragmatic way and do something about this other than simply verbal exchange this year. There are a lot of people hurting and we need to address the problem. You are addressing it. Thank you. I yield back.

Chairman THOMAS. I thank the gentleman. The gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Thank you, Mr. Chairman.

Welcome, and we are glad you are here. I am going to go through a scenario, and I will tell you it came from the Center on Budget and Policy Priorities, but I think it sets it out in a kind of a way that Members might understand a little bit of what is going on and some of the concerns that we might have.

And prefacing that and saying that I probably, like has already been mentioned, was one of those that thought we ought to give tax credits to farmers, tax credits to the self-employed and those. I mean, I think we all have looked for ways to try to bring in the uninsured into a system that works for them. But I am very concerned that we are disrupting something that is already taking place in the marketplace, and really just looking at one system of where we just give it to people outside of the system or move outside of the system, instead of closing some gaps that we have in the system that is already there.

So the story is, if you assume a company provides a comprehensive health insurance play to its two employees, John is 28 with a healthy family of three. The cost of the family coverage plan for John through the employer-based system would be $3,000. Mary is a 45-year-old woman with a family of three that has a history of chronic, serious medical problems. The cost of a plan for Mary is $12,000.

However, because both workers are in the same health insurance pool, the health insurance cost through the company averages to $7,500 a year. Since the company subsidizes 80 percent of the cost of health insurance, it would contribute $6,000 per year for the cost of health insurance and the workers would pay $1,500 a year.

If John instead buys health insurance for his family in the individual market, he might be able to purchase a policy that costs about $3,600. It is a little bit more than the cost of a plan in the employer-based system, since individual insurance is usually more expensive than the employer-based coverage for the same level of coverage. Because he and his family are in excellent health, they can obtain a policy in the individual market.

Under the Administration's proposal, with a tax credit of $3,000, John can save $900 a year by dropping his employer-sponsored plan and buying a plan in the individual market. His net cost is $3,600 minus $3,000 or $600, while he currently pays $1,500 for his employer-based.

But if John drops out of his employer's plan, then only Mary is left in her company's health insurance pool, and the average cost of insurance for the firm rises from $7,500 to $12,000. If the company continues to subsidize at 80 percent of the cost of health insurance, the employer contribution toward her insurance would rise to $9,600 because John is no longer there and available to bring the average cost of insurance down.

Accordingly, Mary's premium would rise from $1,500 to $2,400. It is likely that Mary would be unable to afford the higher premium and continue to participate in her employer's health insurance plan. She and her family would be eligible for a $3,000 tax credit to buy health insurance in the individual market, but because of the medical problems obviously that would not work.

And just in a note, there in Florida you might know they closed their high-risk pool. They were $100 million in deficit. Mary may live in Florida. She has no place to go at that point.

But on the other hand, if Mary's company may be unable to increase its contribution to the cost of health insurance, it might just balk at increasing the company contribution by $3,600 per year, making it more likely that Mary would be unable to afford the em-

ployee contribution, or decide against offering health insurance altogether, which the company could do, knowing that Mary has a tax credit available to purchase coverage in that individual market.

In this very simple example, John has used his tax credit to buy insurance in the individual market, but since he already had insurance, there is no net reduction in the number of uninsured people. On the other hand, it may become harder for Mary.

I know that is a long thing, and I am sure that at some point—so the question is, you know, I understand why you are trying to do what you are doing, but why would you not open this up, instead of being disruptive to the total market, to the businessman? Why would you not put the incentive with the businessman as well to offer that insurance and to give that tax credit? Why would we just do it on an individual basis? I am very concerned about these kinds of stories that we are going to come back and hear because we have disrupted a market that is working.

Mr. MCCLELLAN. We totally agree with you about the importance of closing gaps in the system and strengthening all parts of the system. Just one factual point on that example you gave. John, the employee who would go outside of the pool and would take this additional income, would have to pay taxes on that income, so it is going to be worth substantially less. And, unless he was a very low-income worker, he is not going to get the full value of this tax credit.

So the result of that is that there isn't very much crowding out of employer coverage. Around 1 percent of employees who have health care coverage now through their employers would take this option instead. It is a very small part of the pool, and that is because there are such big tax subsidies through the tax deduction for this unlimited into employer coverage, and there also are the benefits of employer contributions and the pooling that employers can provide.

In addition to implementing this proposal, however, we agree with you that we ought to strengthen employer coverage. We have proposals like the flexible spending account proposal, so that people like Mary would have to pay less after tax in their out-of-pocket health care cost. We have other proposals——

Mrs. THURMAN. But we already have a cafeteria plan. I mean, we can do that today.

Chairman THOMAS. I thank the gentlewoman for showing some of the flaws in the current system. The gentlewoman from Washington wish to inquire?

Ms. DUNN. Thank you very much, Mr. Chairman. And gentlemen, thank you for coming today. I have appreciated very much the work that we have all done together over the last year, the 2-hour meetings that we have done through many, many weeks, and I think the consistency of your being available to answer our questions and work with us on a bipartisan basis needs to be noted for the record.

I wanted to go back to something Mr. Kleczka was talking about. The President and other folks who are supporting tax credits to reduce the uninsured I think are on the right track, but I really would like your opinion on whether you believe that these tax credits might cause some employers to drop their health care coverage.

And if you believe that that is where the incentives are headed, what can we do right now to prevent that sort of erosion?

Mr. WEINBERGER. Congresswoman, as I think was discussed, the purpose and aim of this credit was to have minimal disruption of any insurance offered in the employer-provided market. When you expand any incentive to individuals, there is a risk that some might leave an incentive that they have somewhere else, like through the employer-provided system. The same would be true if you expanded Medicaid or any other type of proposal to cover people who currently don't have benefits or try to aim at that market.

As we suggested, out of the 170 million people who are in the employer coverage—that was the number, I think, that Mr. Kleczka used—our estimate is that less than 1.5 million or less than, 1 percent, would actually leave the employer market. The vast majority of people that would take the benefit of this incentive, again which is aimed at those people who don't have the benefit of employer coverage in these cases, are individuals outside that market.

And so, obviously this is an issue we have got to watch. It is important to look at how the effect of these individual incentives will affect the employer market. But we designed this in a way that it is targeted to those individuals who would least likely be in a position to leave the employer-provided plan.

Ms. DUNN. Good. That is important for us to note.

I wanted to ask you a question having to do with my part of the country. I am from the Seattle area, and as you know, many folks out there are currently losing jobs, work for Boeing, Northrop, other companies, and so we are not in a great position right now. In fact, we are number two on the list of the highest unemployment numbers in States around the Nation, after Oregon.

As we talk about the uninsured, I would like for you to reiterate in a way that is easy to understand, the difference between your policies and how you would approach the problems of the uninsured when it comes to coverage, and the unemployed.

Mr. MCCLELLAN. Can I highlight proposals that I think would be of great assistance in the immediate future for people in your district who have lost their jobs? And you are right, there are a huge number of them. The President spent some time out on the West Coast lately, and has seen firsthand how important it is that we do something right away to help them.

Our displaced worker credit could be implemented within a few months, and as soon as it is implemented, those workers would know that they have got help on the way. They will know that premiums that they have to pay now are going to get reimbursed at the end of the year, 60 percent of the premiums will, and they will know that within just a few months they will able to pay much lower costs for continuing their health insurance because they can use the advanceable credit.

Sixty percent of their costs of health insurance, while they are buying it, would be paid directly by the credit. And this would enable the vast majority of people, not only in your district but around the country, who have lost their jobs to continue health insurance coverage, whether it is COBRA coverage if that is what they prefer, or mini-COBRA coverage if they are in a State that has similar laws to COBRA, that are not the same as COBRA but

that allow people in small firms to continue their coverage, like Washington does.

And it would also allow people who are purchasing coverage outside of their employer. Many displaced workers do not have employer coverage to begin with. That is 10 percent of the non-elderly with health insurance today don't have employer coverage to begin with. They would get help.

So all of these displaced workers would get help quickly, without the need for further State legislation to come up with matching funds and set in place some new kind of unprecedented Medicaid expansion, and without the need for mandates on employers like Boeing that are facing enough problems right now without the government telling them yet more things that they have to do in a difficult economic time.

Mr. WEINBERGER. Congresswoman, could I just underscore one thing that Mr. McClellan said, I think is important? Because the proposal we have for the displaced worker would help those at Boeing, but it would also help all the small businesses in your State as well. And that is one of the concerns we had about the COBRA credit. Where small businesses generally don't provide COBRA, they would not qualify for this immediate benefit.

Ms. DUNN. I think that is very important, Mr. Chairman, and I think that needs to be reiterated, this business of being willing to cover COBRA payments that folks get when they work for big businesses, but the fact is, the small businesses can't provide that sort of coverage. For example, if you work for a company that has fewer than 20 employees and you try to get COBRA, as I once did, you can't get covered for anything. How do you suggest that we incentivize small businesses to provide affordable health insurance coverage?

Mr. MCCLELLAN. We have a number of proposals in our budget to help small businesses provide affordable coverage. One of them is our association health plan proposal, which would make it possible for small businesses to pool together just like large corporations do to offer a lower-cost range of health insurance options to their employees. This is a proposal that is strongly supported by the small business lobby, would enable groups like the Chamber of Commerce, other organizations, to serve as a conduit for health insurance for those.

Chairman THOMAS. The gentlewoman's time has expired. The gentleman from Georgia wish to inquire?

Mr. COLLINS. Yes, sir. Thank you, Mr. Chairman.

You know, I very well understand the intent of what you are trying to do with your proposal on the tax credit. However, I have a real problem with the tax credit provisions, because as you issue a credit on one side, someone has to make it up on the other side if you are going to have a balance in your Treasury. And, two, to me you are creating an entitlement within the Tax Code, one that is means tested, based on income.

So you have a situation where you are creating an entitlement for certain incomes to be able to get a credit, a refundable credit. Then you have others who will be paying the tax that covers that credit, based on a means test. I don't like that at all.

It has been talked about the employer-based insurance, where the employer provides insurance, versus privately purchased insurance. There is a real difference in employer-provided, whether it be all of the premium or part of the premium for the employee, because the employer gets to deduct that from the cost of operation. But if it is privately purchased insurance, the employee does not get to deduct from their taxable income.

I will give you an example of a small business in a little town in Georgia. It is a sub S corporation, three employees. Two of those employees actually have other jobs also, and those two are covered under group insurance or insurance from the other employers. One employee is covered with a private policy paid for by that sub S, but at the end of the year the premium for that policy has to be added to the income of that employee, no deduction anywhere.

And based on your means testing, your entitlement program that you are setting up through the tax credits, his income of he and his wife would just exceed what you are trying to do, so he has no assistance at all, but he will be paying additional income tax to help support what you are doing. I think you are totally wrong in your approach with the tax credit. I think what you need to look at is how you can assist an individual for their income, as far as a deduction for the cost of premiums.

You know, there are all types of programs out there when it comes to health care. Some we are embarrassed to participate in because it may make us appear to be indigent or it may make us appear to be poor. But I am also concerned that we put in place programs that disincentivize a person's will to work because of increased, increased, increased government programs that offset that will.

I would be very careful as to how I took an approach to this situation with tax credits. I am afraid the tax credits will come back to haunt you in the end. Thank you.

Mr. MCCLELLAN. Representative, we certainly appreciate your caution. I think a number of the comments here at the session today have indicated how difficult and careful we must be in approaching the problem of uninsurance, and also how there is not just a one-size-fits-all solution that is going to address every gap and problem with our health care system.

We do think that health credits can provide important assistance for some individuals who are having trouble purchasing individual coverage today, but we don't pretend that this is our whole solution to the problem of uninsurance. We have a range of other proposals that will strengthen employer coverage and that will also help people like the individual you describe get more affordable coverage.

For example, he could potentially be eligible for our health account proposal. This would allow him to deduct his out-of-pocket payments for health care and to get better protection at a lower cost for seeing the doctors that he wants and getting the treatments that he prefers. This is another part of our entire agenda on health care coverage. So we would very much like to take steps to help that kind of individual at the same time as we are helping lower-income families.

A final point on this, on the refundable credit, is that it is not based on your current income. The advanceability is based on prior

year's income, so that we are encouraging people to get help when they need it most and then to get back into a good job that can provide them coverage as well.

Mr. COLLINS. Young man, take your blinders off and the plugs out of your ears and listen to what people are trying to tell you. Government can't do everything for everyone. It won't work. You are digging a hole that we can't get out of. We can't financially cover everything that you want to do.

We are debating campaign finance reform today. The biggest problem in this town is, we use the Treasury to develop programs for voter base, and we are digging the hole deeper and deeper, and what you are doing with this is, you are using two shovels instead of one.

I was at church Sunday. The pastor says, "Man who doesn't work, doesn't eat." Don't put in place disincentives for man to work, that the government is going to take care of everyone from the womb to the tomb. It won't work, fella. Take your blinders off and the plugs out of your ears and listen to what people are trying to tell you, people who are paying the bill. That happens to be my business. That one person happens to be my brother-in-law. Thank you.

Chairman THOMAS. I thank the gentleman.

Several Members have indicated they would like a brief second round if possible, and if we can be brief in our questions and brief in our responses, we might be able to accommodate the Members.

The gentleman from Washington?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I have been sitting here thinking about my aerospace mechanic, so I am back to him. He is now unemployed, and he goes down to the unemployment office, and I heard you say that he fills out his application for his unemployment and while he is there, he fills out an application for some kind of a tax credit for his health insurance.

Now, if he exercises his COBRA option and wants that money applied to what he already has with Aetna or whoever it is, you would send the money from the government directly to Aetna?

Mr. MCCLELLAN. Yes, sir, that is correct.

Mr. MCDERMOTT. And would you wait until his—where would he send his part of it? Would he have to send it to Aetna?

Mr. MCCLELLAN. He would send, just like he would do otherwise, he would send his check to the insurance company for his part of the premium, and the credit would make up the difference.

Mr. MCDERMOTT. So if he missed a payment and it ended his insurance, how would you know when you should stop sending your checks to Aetna because he isn't covered anymore?

Mr. MCCLELLAN. Well, there would be a reconciliation mechanism in place to make sure that the employee is still eligible for unemployment insurance and also is still making the actual payments on his health insurance. The insurance company couldn't get reimbursed by the government for a policy that they are not providing.

Mr. MCDERMOTT. So that would be one way you would get it back. Now, let's suppose he gets down the road and something happens and he says, "Wait a minute, I can't afford $7,000 a year, so

I've got to reduce my costs here, and the jobs don't seem to be coming back, so I want to go out and get one of these programs on eHealth or whatever I can find somewhere for $3,000." Now, can he come back and change it with you?

Mr. MCCLELLAN. Yes.

Mr. MCDERMOTT. And so you are perfectly willing to allow him to take a lesser coverage?

Mr. MCCLELLAN. Well, our goal is to help the people get the coverage that they most prefer, the coverage that best fits their needs. So if individuals are not eligible or are not offered good COBRA options, then they would be able to use the credit for other coverage choices, as well.

Mr. MCDERMOTT. So if this, you are essentially saying that if this chart from eHealthInsurance is anywhere close to correct, you would be willing to pay for a policy where there was no guaranteed set of benefits, just you are going to send a premium out for $3,000 for something that might not cover the emergency room or doctor's visits or anything else.

Mr. MCCLELLAN. There are some coverage requirements in the proposal and in the bill that passed the House, and they are consistent with a broad health insurance plan. Again, we think it is in the best interest, especially these workers, as you mention, they are on limited income, they are between jobs, and they need coverage that fits their unusual current circumstances. So we would prefer to put our faith in them to choose the coverage that is best for them, subject to the health insurance standards in the bill.

Mr. MCDERMOTT. One thing I didn't understand, though. You said the bill that passed the House had some coverage requirements. Which bill was that?

Mr. MCCLELLAN. This was the economic stimulus bill.

Mr. WEINBERGER. Yes, you are referring, Congressman, to the Displaced Worker Credit which was part of the stimulus bill, so that was the one.

Mr. MCDERMOTT. And there was coverage requirements in there?

Mr. MCCLELLAN. Yes, there were HIPAA, Health Insurance Portability and Accountability Act 1996, standards of coverage.

Mr. MCDERMOTT. Where were they? I mean, does anybody know?

Chairman THOMAS. Yes, there were standards that are currently in the law——

Mr. MCCLELLAN. Accepted benefits that are currently in the law, in HIPAA. It's the same as current law, correct.

Mr. MCDERMOTT. So they covered major medical and doctor's office and so forth?

Mr. MCCLELLAN. They are the standards in law for private health insurance premiums, for private health insurance plans.

Mr. MCDERMOTT. But that was only a guaranteed issue question, wasn't it? Were there actual standards beyond that in terms of what had to be covered?

Mr. MCCLELLAN. The HIPAA legislation describes what constitutes a health insurance plan for purposes of the legislation. It excludes, you know, disease-only plans, narrow cap benefit plans, things like that.

Mr. MCDERMOTT. Okay. Thank you.

Chairman THOMAS. The gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON OF CONNECTICUT. Just briefly, I want to put on the record very clearly because I think we forget, this Committee, this Nation provides $118 billion in subsidies to employer-provided health plans. There is no one listening to this hearing that has an employer-provided insurance program that isn't Federally subsidized, and a lot of us only want that same subsidy to go to Mac Collins' brother-in-law and people who don't have health insurance.

Under my bill if you are at certain incomes it is a credit, at higher incomes it is a deduction. Everyone ought to have the same access to the subsidy of health insurance that we currently provide to people who work, have employer-provided plans.

Now, I do not agree that we should get away from the employer-provided program. I like that. Employers do a lot of good bargaining, a lot of protection. You know, there are some good aspects to that. And I like the Administration's emphasis on allowing new groupings, so individuals can use their tax credits or deductible status to move into new groupings.

But I want to—I am going to assume you are going to answer this question in the affirmative, because I want to really get to the other question. I want you to take a look at my bill that does provide tax credits and then deductions. I know we can't afford it now, but it is the direction we need to go.

And then I want to just point out, in terms of the uninsured, and actually in terms of the uninsured as a general problem, Mr. McDermott proposed a bill with a 30 percent credit with a lot of Democrat cosponsors from this Committee.

What we are talking about for the unemployed, and this is what I want, really want to get to, on the floor we have an opportunity to provide a 60 percent premium subsidy, double the subsidy that has ever been proposed and more generous than my tax credit, I believe, for unemployed people without health insurance. This is a 60 percent premium subsidy, so this is a powerful assist to the uninsured and unemployed. And I just hope that we won't lose track of what we are doing here.

And what I want to ask you is, what is the comparison between our 60 percent subsidy for essentially all the people that are unemployed, versus their subsidy for just those who have COBRA or have Medicaid coverage? Now, a lot of people who are working don't want to go on a welfare program, and Medicaid is a welfare program. And a lot of States can't afford to increase their welfare spending right now anyway.

So this is a big difference, and we are going to be out there on the floor this week or next week. We are going to have the chance to vote to give people who are struggling with unemployment the opportunity to have a 60 percent premium subsidy, whether they work for a company who offers COBRA or whether they don't. And I think you need to give us a little better insight into the power of the proposal you are recommending we work on, that we have developed, versus the alternative that is going to be on the floor,

that is going to help many fewer people with a much less powerful subsidy. Now, that is my question.

Mr. MCCLELLAN. Congresswoman, we couldn't agree more about the need for bold action right now, and we think the proposal that the House has developed, has already passed once, ought to become law to provide this kind of assistance to people who have lost their jobs. We think it is a far more effective proposal than others that have been put forth.

The President really laid out two goals for us on what our objectives should be in providing assistance with health care costs for workers. We need a proposal that can be implemented quickly, we need a proposal that can be targeted to all people who have lost their jobs involuntarily, and this proposal wins on both counts.

COBRA subsidies are not only difficult to implement because they impose new mandates on businesses, they are also poorly targeted to people who have lost their jobs involuntarily. Most of the people who would be eligible and most of the subsidies under the COBRA proposal would go to people who did not lose their jobs involuntarily.

The Medicaid proposals are not the right medicine for people who want to continue their coverage, their private insurance coverage, but don't happen to be eligible for COBRA. It cannot be implemented quickly. As Chairman Thomas pointed out, most States are not in a position to expand coverage to populations that are not their core Medicaid populations, the low-income families and low-income seniors that really do need help now, and that we really want to help the Medicaid and SCHIP programs focus on.

So this is a far more effective way to get help to people who need it quickly, and we appreciate your support for seeing it become law.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Chairman THOMAS. The Chair notes that we are under second bells on a vote on the floor. Any other Member wish to inquire briefly? The gentleman from Louisiana?

Mr. MCCRERY. Yes, Mr. Chairman, just to continue on my concern about the cost of health care, and I know that you all have thought about that because I have had discussions with you about health care costs and where they are going, and what we can do to try to stem the upward spiral of health care costs. And I notice that in your tax credit proposal, not for the unemployed but in general, you do cap that by income, so you limit that subsidy to low-income folks, or really not low-income folks, but at least you cut it off at $60,000 for a family, and that is a start.

The fact is that the tax subsidy that Mrs. Johnson spoke about for employer-provided insurance is not the only subsidy that those employees get. They also get a subsidy from their employer. So not only do they get a tax break, and depending on your tax bracket, I mean, it could average say 25 percent that you are going to get, a cut on the cost of the premiums from the tax subsidy, but you are also getting 50 percent, 75 percent subsidy from your employer.

So the employee that is getting that tremendous subsidy for his health insurance has no idea generally what it costs, really, so he has no price sensitivity in the marketplace. He doesn't care generally how much health care costs. He knows it is covered, so he gets it.

When you subsidize something, you get more of it, and you are going to subsidize more health insurance so we are going to get more health insurance. But you are also subsidizing health care, and you are going to get more health care when you subsidize it more.

I am just wondering, since the Administration put in your proposal some cap here for your general tax credit, did you consider and would you consider some cap on the tax subsidy that we provide, so that we can start to bring some price sensitivity back into the marketplace for health care?

Mr. WEINBERGER. Well, we have not, as you know, designed this proposal to look at the employer system. We have designed this proposal to reach out to those people who are generally not covered by the employer system, and the cap that we have was aimed at actually trying to minimize to some degree what others have raised, which was having employees leave the employer market in this circumstance.

What you are talking about, Mr. McCrery, obviously is a much broader reform proposal, and we are certainly willing to sit down and talk about that, but this proposal was not designed with that type of a thought process in mind.

Mr. MCCLELLAN. I would also like to add that the President certainly shares your goal of helping make sure that people have affordable coverage options and they are not just given, you know, one plan that provides very generous coverage and no other choices. The President laid out on Monday, in his speech about his agenda for the future of health care, the importance of giving all Americans a range of choices about how to get their coverage, and it is through that kind of competition that our private health care system can find innovative and more cost-effective ways of delivering coverage. We need to encourage choice and competition. We need to encourage better information. I think your ideas go very far in that direction.

Chairman THOMAS. The Chair does find it ironic that the Administration, as the way you put it was that you put a cap on a provision for those who do not have insurance so that we wouldn't undermine a system in which there is no limit on the availability and therefore, as the gentleman from Louisiana said, no discretion in price sensitivity. Some folks find that pretty ironic.

The Chair would indicate that we have a short time on this vote, but thank you very much for your attendance and your indulgence. The second panel requires some degree of electronic set-up, and to allow that to occur, the Committee will stand in recess until 1:30, at which we will then enter into the presentation and a discussion with the second panel. The Committee stands in recess.

[Recess.]

Chairman THOMAS. The Chair thanks the Members of the panel. Members will be coming back from the vote. As you may know, there is a degree of construction going on, and we are currently running a gauntlet trying to get back and forth.

This panel will consist of Dr. Stuart Butler, Vice President, Domestic and Economic Policy Studies, Heritage Foundation; thanks for being with us. Iris Lav, Deputy Director, Center on Budget and Policy Priorities; Jeff Lemieux, Senior Economist, Progressive Pol-

icy Institute, and Vip Patel, Founder and Chairman of eHealthInsurance, Inc., in Sunnyvale, California.

Due to the antiquated wiring in this room, any attempt to go electronically produces a reverb back through the system. And so to assist Members, although logically we would probably like a general discussion and then some specific examples, the Chair will request that the other Members allow us to allow Mr. Patel to go first, so that if there are any questions of his presentation, we can conclude that and then perhaps turn that system off so that Members would not get the reverberation back through their microphones.

Each of you have a written statement. We will accept the written statement for the record, and within the time allowed, you may respond to us in any way you wish to present your arguments or position. Mr. Patel, nice to see you again, and would you please begin the panel?

STATEMENT OF VIP PATEL, FOUNDER AND CHAIRMAN, EHEALTHINSURANCE, INC., SUNNYVALE, CALIFORNIA

Mr. PATEL. Mr. Chairman, Mr. Rangel, Mrs. Johnson, Mr. Stark, and Members of the full Committee, over the last 5 years the process for individuals seeking to purchase their own health insurance has gone through a dramatic positive transformation, and in these next few minutes I would like to contrast the old, inefficient way of purchasing individual health insurance, a process which took weeks, to a new way of shopping online, a process that could take as little as an hour and in which the consumer is much more empowered.

The old way versus the new way. First, in just finding a broker, many people don't know where to go to find a broker. In the old way, people might turn to their friends for a referral and possibly schedule a meeting with a broker days later. In this new way, people search on Yahoo or their favorite search engine. They are presented with a wide variety of resources for health insurance shopping, from insurance carriers themselves to thousands of health insurance brokers with Web sites, to national marketplaces like www.ehealthinsurance.com.

In this example I am entering the zip code of Congressman Stark's district in California, which also happens to be the headquarters of eHealthInsurance. A full list of policy options will be presented without entering any personally identifiable information, and only the ages of those to be covered, so let's input a family of three. Please note the convenience of Web sites operating around the clock, 24 by 7, and you can talk to a licensed professional on a toll-free number.

Number two, comparison shopping across a wide range of insurance companies. In the old way, some brokers specialize in only one or two insurance companies. For example, a broker may emphasize a policy from Blue Shield because they could win that special trip to Hawaii, and that may not be in the optimal interest of their customer. Hence, a consumer may need to see several brokers to explore a broad selection of options. But in this new way, consumers can explore a wide array of options with one stop shopping. Take

a look at this first column here, a highly competitive marketplace with a number of insurance companies fighting for your business.

Number three, getting an unbiased look at all the price alternatives. In the old way, a broker may ask about your employment and budget to qualify which insurance products to recommend to you, and of course the higher the price, the more commission made by the broker. But in the new way, the full range of insurance products of each company is presented to the consumer, and at eHealthInsurance this is done by showing the lowest price all the way to the highest price products, and I think here there is a 7X delta between the lowest and the highest. We believe consumers want unbiased presentation where they can sort by factors important to them, and here we will sort by deductible.

Number four, obtaining a clear, apples-to-apples comparison of what you are buying. You know, health insurance is full of confusing, industry-specific jargon, and in the old way comparing options is made even more difficult when you are only able to see the benefit information across a few policies on several different pieces of paper. But in this new way there are online glossaries to instantly explain unfamiliar terms, such as the definition of an HMO or a PPO.

And then most powerfully, with the click of a few buttons, a number of different policies can be compared by a wide range of features for apples-to-applies comparison. Consumers can pick from HMOs, PPOs, MSAs (medical savings accounts), indemnities, etcetera, but in this example let's narrow our focus to comparing three different PPOs that all have a $1,000 deductible, that all have 20 percent co-pay, to see what really makes them different, and I think the details will be easier to see in the handout that you have been given.

But in this example we find that if you are anticipating the need for prescription drugs or maternity care, maybe the Health Net or the Blue Shield products may be good, but if you are a single healthy male, the Blue Cross PPO could be the best value. However, the deciding factor could be whether your favorite doctor is part of the plan, and in most cases health plans make their physician directories available right online.

Finally, in the old way versus the new way of completing an application, it is no surprise that applying online gets the consumer health insurance faster than communicating by mail.

Now, every day people approach eHealthInsurance with the misperception that health insurance is prohibitively expensive, but when they see the range of options, starting with some with very low prices, many of them find that they can in fact afford health insurance. And of course many more people could afford health insurance if the government were to provide economic assistance.

No one solution will solve the entire problem. Although some of the unhealthy and impoverished uninsured need specific solutions, I do believe honestly that tax credits represent one of the most impactful solutions for the working uninsured and the newly displaced uninsured, which together make up over two-thirds of the 40 million uninsured population.

eHealthInsurance just performed an analysis of 20,000 single policies sold, not just random quotes as you might find in some of

these documents, the actual sold policies in the United States representing 93 percent of the U.S. population. So this new data shows that the average price of a policy was $159 per month or $1,900 per year, with the majority of these policies carrying less than $1,000 deductible.

And even more revealing is the average price by age bracket compared to the percentage of the uninsured in each age bracket. If for example under the Bush proposal you were able to offer a $1,000 tax credit, then two-thirds of the uninsured, those 34 and younger, could get a policy for the balance close to $50 per month, and 80 percent of the uninsured, those 44 and younger, could get a policy for the balance of $100 a month.

And with the recently passed House proposal, where the government pays for 60 percent of the premium, all age brackets could be covered with a balance close to $100 per month, and you could feel good about the fact that they are getting fairly comprehensive policies with modest deductibles. With that type of impact in your reach, now I'm not sure why anyone would be against a tax credit that could help such a large segment of the uninsured.

[The prepared statement of Mr. Patel follows:]

Statement of Vip Patel, Founder and Chairman, eHealthinsurance Inc., Sunnyvale, California

Introduction

- Mr. Chairman and Congressman Rangel, thank you for the opportunity to testify today and let me thank you both, and the Members of this Committee, for your interest in, and work on behalf of the nation's uninsured. I am present today to tell you about the experience of eHealthInsurance and, to whatever extent possible, provide information to you to help you address the pressing need to assist the uninsured in obtaining health care coverage.
- Yet first I want to briefly explain my background and more specifically, my passion for addressing the problem of the roughly 40 million uninsured Americans today. Studies show that we need to help the uninsured because they allow their health to deteriorate before seeking medical assistance. I understand this first hand, having waited until suffering painful internal hemorrhaging before visiting a health facility, only to be turned away to a county facility because I was without health insurance. Studies also show that we need to help the uninsured because they face significant life disruption when they are caught seriously ill without health coverage. Again, I understand this vividly having watched my maternal uncle, a then-uninsured member of my own family and recent U.S. citizen encounter the life disruption of returning back to India to obtain treatment after a stroke.

  These personal experiences helped fuel my entrepreneurial spirit in becoming the Founder of eHealthInsurance.

eHealthInsurance Helping Real People in Need

- eHealthInsurance is a nationwide marketplace for individuals, families and small businesses to research a wide range of insurance companies and then purchase the health insurance that best fits their needs. Surprisingly, 40% of the people who complete applications with eHealthInsurance state on their application that they have been uninsured for a significant period of time—yes, 40% of eHealthInsurance applicants come from the uninsured. A number of people approach eHealthInsurance with the misperception that health insurance is prohibitively expensive, but when they see the range of options, starting with some very low prices, many of them find they can afford health insurance. Of course, many more people could actually afford health insurance if the government were to provide economic assistance to overcome the affordability barrier.

Just as important as my own story are the stories of people who have used eHealthInsurance to overcome their challenges of becoming or staying insured. Here are some of their actual statements (taken from TV news story transcripts):

1. Donna Johnson of Sacramento, California is a 35-year old single mom with 12-year-old son named Paul. She works as a manicurist, and Paul had asthma for most of his life. The two were without health insurance for 11 years, and paid more than $15,000 in medical bills out-of-pocket.

   To not have health insurance, and to have either you be sick or your children be sick and have to go to the doctor, you're scared, you're afraid that the doctors are going to turn you away, you're afraid the hospitals are going to turn you away because you're not insured."

   "It's the worst thing to have your kid in a hospital, hooked up to wires and machines and you don't have any money to pay for any of this. I didn't know what I was going to do."

   When she heard about eHealthInsurance, Johnson went online to see if she could get health insurance, even though she didn't really think she could. To her surprise, Johnson and her son were approved for coverage through eHealthInsurance in a few weeks. She now pays $225/month and is fully covered, even with son Paul's pre-existing condition.

   "I was just so overwhelmed by everything I had been through, all of the years that I had gone through without the insurance, all the money that I paid, (when I received the cards in the mail) I sat in my chair and I cried, because it was just the best feeling that I had had in a lot of years."

2. Venus Campanelli of Chicago, Illinois is married, works part time, and has two children. Her husband is self-employed.

   "We know now that we can afford (health insurance), we don't have to worry about that payment every month, and say 'Oh, my God, this is taking a big bite out of our budget every month.'"

   "We got a cheaper deductible by half and the payments went down by half, for basically more coverage."

   "Especially when you have little ones, they fall, they cut themselves. My son had stitches, so (insurance) is important."

3. John Fritz, of San Jose, California was laid off from his job in 2001. He is married, with two children under the age of four.

   "(My) company did offer COBRA, but with the HR person rolling her eyes saying, 'if you really want COBRA, here it is' . . . "but it's bloody expensive." The company's COBRA premium would have been a little more than $1200/month for Fritz's family of four.

   "When you've got two kids, you've got immunizations and who knows what else to worry about," Fritz said.

   He went to eHealthInsurance.com and found comparable coverage to his COBRA plan for only $150/month with the doctors they wanted.

   "It wasn't three weeks before we had to put it to use when my newborn daughter got pneumonia. So that covered the costs right there."

Real Data to Assist Policy Makers

- The employees of eHealthInsurance, whom I am representing here today, come from all parts of the political spectrum. Hence, eHealthInsurance is non-partisan. Over the last several years, eHealthInsurance has advanced a challenge to numerous policy makers to cut the uninsured by half by the year 2010. We've met with Democratic and Republican leaders in the Senate, House and with both the Bush and Clinton Administrations. Along with issuing the challenge, eHealthInsurance is prepared to help and to work alongside the Congress to accomplish this worthwhile objective.
- We discovered that policy makers and influencers seeking to help the uninsured are in real need of accurate information about the expense and comprehensiveness of health insurance purchased by individuals and families. Because of eHealthInsurance's national reach and volume, offering 10,000 different plans from 100 different insurers, with licenses to sell insurance in all

50 states and the District of Columbia, we are in perhaps we are in a relatively exclusive position to provide such information.

- That leads us to some new information we would like to share with the Committee today. In January 2002, eHealthInsurance pulled a recent sample of 20,000 individual (single) sold policies from its database of customers to better understand the cost and comprehensiveness of health insurance policies purchased by individuals. The following data shows the costs of the plans actually selected and benefits received by individuals buying on the private health insurance market. The purchasing behavior is representative of what people purchase in a health insurance plan when they pay for it themselves.

Premiums Within Reach Across Most of the Country

The average individual (single) premiums that consumers in this sample purchased is $159 per-member-per-month (PMPM) (which is slightly higher than the average family policy at $110 PMPM). On an annual basis, this individual premium amount equates to $1,900 per-person-per-year. This amount is substantiated when compared to the average PMPMs of some of the nation's largest individual health insurance carriers. Such premiums are available to states representing 93% of the U.S. population. Almost two-thirds of the uninsured population fall in age brackets with an average annual premium of less than $1700, which is even below the overall average of individual premiums.

Health Insurance Premiums for Single Policies by Age Bracket

	age <18	age 18–24	age 25–34	age 35–44	age 45–64	65 and older (4)	all ages
Average monthly premium per single (1)	$102	$123	$138	$182	$262	N/A	$159
Average annual premium per single	$1,226	$1,481	$1,658	$2,178	$3,144	N/A	$1,908
% of uninsured population by age (2)	24%	18%	21%	17%	19%	1%	100%
% of U.S. population by age (3)	25%	10%	14%	16%	22%	12%	100%

(1) Source: eHealthInsurance, Inc. 2001, 20,000 single policies across states representing 93.5% of the U.S. population
(2) Source: Health Insurance Coverage, US Census Bureau, issued Sept 2000
(3) Source: U.S. Census Bureau, Census 2000, with extrapolation
(4) Age 65 and older are covered under Medicare

State	Population	% of U.S. Pop.	Avg. monthly premium per single: all ages	Avg. annual premium per single: all ages	Average age	Guaranteed Issue (2)	Community Rating (3)
California	34,501,130	12.1%	$143	$1,718	30		
Texas	21,325,018	7.5%	$143	$1,716	32		
New York	19,011,378	6.7%	$266	$3,198	35	Yes	Yes
Florida	16,396,515	5.8%	$287	$3,448	33		
Illinois	12,482,301	4.4%	$174	$2,088	32		
Pennsylvania	12,287,150	4.3%	$164	$1,962	31		
Ohio	11,373,541	4.0%	$153	$1,837	33		
Michigan	9,990,817	3.5%	$161	$1,934	32		
New Jersey	8,484,431	3.0%	$203	$2,436	38	Yes	Yes
Georgia	8,383,915	2.9%	$127	$1,521	30		
North Carolina	8,186,268	2.9%	$121	$1,450	34		

State	Population	% of U.S. Pop.	Avg. monthly premium per single: all ages	Avg. annual premium per single: all ages	Average age	Guaranteed Issue (2)	Community Rating (3)
Virginia	7,187,734	2.5%	$148	$1,778	32		
Indiana	6,114,745	2.1%	$136	$1,633	31		
Washington	5,987,973	2.1%	$129	$1,545	34		
Tennessee	5,740,021	2.0%	$155	$1,866	33		
Missouri	5,629,707	2.0%	$172	$2,066	31		
Wisconsin	5,401,906	1.9%	$174	$2,090	33		
Maryland	5,375,156	1.9%	$166	$1,986	31		
Arizona	5,307,331	1.9%	$139	$1,672	34		
Minnesota	4,972,294	1.7%	$165	$1,975	31		
Louisiana	4,465,430	1.6%	$166	$1,995	30		
Alabama	4,464,356	1.6%	$133	$1,602	27		
Colorado	4,417,714	1.6%	$151	$1,816	32		
South Carolina	4,063,011	1.4%	$137	$1,650	31		
Oregon	3,472,867	1.2%	$135	$1,625	30		
Oklahoma	3,460,097	1.2%	$133	$1,597	34		
Connecticut	3,425,074	1.2%	$153	$1,838	37		
Iowa	2,923,179	1.0%	$144	$1,723	34		
Mississippi	2,858,029	1.0%	$170	$2,038	31		
Kansas	2,694,641	0.9%	$121	$1,446	33		
Arkansas	2,692,090	0.9%	$146	$1,751	35		
Utah (1)	2,269,789	0.8%	$93	$1,117	28		
Nevada	2,106,074	0.7%	$166	$1,995	35		
New Mexico	1,829,146	0.6%	$164	$1,972	36		
Nebraska	1,713,235	0.6%	$185	$2,223	29		
Rhode Island	1,058,920	0.4%	$181	$2,174	32		
Montana	904,433	0.3%	$173	$2,073	31		
Delaware	796,165	0.3%	$165	$1,980	31		
South Dakota	756,600	0.3%	$165	$1,986	42		
Alaska	634,892	0.2%	$216	$2,592	32		
District of Columbia	571,822	0.2%	$143	$1,713	31		
Wyoming	494,423	0.2%	$128	$1,537	35		
Totals	**266,211,318**	**93.5%**	**$159**	**$1,907**	**32**		

State	Population	% of U.S. Pop.	Avg. monthly premium per single: all ages	Avg. annual premium per single: all ages	Average age	Guaranteed Issue (2)	Community Rating (3)
Not Included: Massachusetts	6,379,304	2.2%	N/A	N/A	N/A	Yes	
Kentucky	4,065,556	1.4%	N/A	N/A	N/A	Yes	
West Virginia	1,801,916	0.6%	N/A	N/A	N/A		
Idaho	1,321,006	0.5%	N/A	N/A	N/A	Yes	
Maine	1,286,670	0.5%	N/A	N/A	N/A	Yes	Yes
New Hampshire	1,259,181	0.4%	N/A	N/A	N/A	Yes	Yes
Hawaii	1,224,398	0.4%	N/A	N/A	N/A	employer mandate	
North Dakota	634,448	0.2%	N/A	N/A	N/A		
Vermont	613,090	0.2%	N/A	N/A	N/A	Yes	Yes
	18,585,569	6.5%					
Total US	**284,796,887**						

(1) Sample skewed young; age bands averaged
(2) Law requires all applicants to be issued a policy regardless of health
(3) Law requires policies to be priced independent of age and/or health

Several States Outside the Norm

In several states such as New York, uncompetitive market conditions can cause significantly higher premiums across all age brackets.

Health Insurance Premiums for Single Policies by Age for Three Largest States

State	Population	% of U.S. Pop.	Avg. single monthly premium: all ages	Avg. single monthly premium: age 18–24	Avg. single monthly premium: age 25–34	Avg. single monthly premium: age 35–44	Avg. single monthly premium: age 45–64	# of Carriers Actively Pursuing Individual Business (1)	Guaranteed Issue (2)	Community Rating (3)
California	34,501,130	12.1%	$143	$107	$132	$175	$238	7	No	No
Texas	21,325,018	7.5%	$143	$108	$124	$160	$228	7	No	No
New York	19,011,378	6.7%	$266	$243	$267	$282	$271	1	Yes	Yes

(1) Number of insurance companies responding positively to offer from eHealthInsurance for expanding members in individual market
(2) Law requires all applicants to be issued a policy regardless of health
(3) Law requires policies to be priced independent of age and/or health

Modest Deductibles and Co-payments

Data from this sample shows that there is a clear consumer purchasing preference for lower deductibles. As shown in the chart below, greater than two-thirds of all

plans purchased have a deductible of $1000 or less, and close to half have deductibles of $500 or less. Additionally, two-thirds of policies have office visit co-payments of $20 or less.

Deductible	% of Policies Purchased	Co-Pay	% of Policies Purchased
$500 or less	43.5%	$0	36.7%
$501 to $1000	25.9%	$5	0.0%
$1001 to $1500	7.5%	$10	9.3%
$1501 to $2000	7.8%	$15	9.2%
$2001 to $3000	10.0%	$20	20.1%
Over $3000	5.3%	$25	6.2%
Total	100%	$30	10.7%
		$35	4.7%
		$40	1.2%
		$45	1.8%
		Total	100%

Solid and Accessible Benefits

87% of policies purchased by individuals can be considered "comprehensive" in coverage, where comprehensiveness is defined to include: Inpatient + Outpatient + Labs&Tests + Prescription Drugs (85%). Consumers purchased mainstream health insurance plan types that are relatively unencumbered with utilization restrictions (e.g., HMO gatekeepers) or non-mainstream, minimal-coverage products.

Benefit Levels of Policies Selected		Product Choices by Individual Customers	
Benefit Coverage	**% of Policies Purchased**	**Product Type**	**% of Policies Purchased**
Comprehensive (1)	87%	PPO	78%
Basic	13%	HMO	10%
Total	100%	Indemnity/Other	11%
		Total	100%

(1) Comprehensive = Inpatient + Outpatient + Labs&Tests + Prescription Drugs (85%)

Tax Credits in the Individual Market: How Far Can They Go?

- In order to be effective in addressing the uninsured issue, we must identify realities of the various segments of the uninsured population. I find it helpful to distinguish between the impoverished uninsured, working uninsured, unhealthy uninsured and newly displaced uninsured or displaced workers. They all require approaches unique to their population. Let me be clear. No one solution will solve the entire problem.
- Although a tax credit is not the only solution for all of the uninsured, I believe it is one of the most impactful opportunities for the working uninsured (25 million) and newly displaced uninsured, which together make up over two-thirds of the 40 million uninsured population.
- By subsidizing the health insurance premiums in the form of $1,000 per person such as proposed by President Bush, or 60% of overall premiums as recently passed by the House, most of those eligible will be able to afford the discretionary income to pay the remaining balance. Their hard earned money together with government assistance will get many people over the finish line.
- If you were able to offer the uninsured a $1000 tax credit, then two-thirds of the uninsured (those age 34 and younger) could get a policy for the balance of $50/month. And 80% of the uninsured (those age 44 and younger), could get a policy for the balance of $100/month. With the alternative proposal of the gov-

ernment paying for 60% of the premium, all age brackets could be covered with a balance close to $100/month. Beyond this, we can feel good about the fact that in most cases they are getting fairly comprehensive policies with modest deductibles. With that type of impact, I'm not sure why anyone would be against helping a large portion of the uninsured purchase tax credits for health insurance.

Appeal for Incremental Progress on All Segments of the Uninsured

- Allow me to end briefly by sharing an observation from my experience with health care policy, even if it is nothing more than an "outside perspective." I have encountered among proponents of 100% consumer based, employer based or government based health care plans a recurring "all or nothing" mentality. As policymakers strive towards such ends, I have found the result for the uninsured to be more of paralysis than progress. I do not believe that any one of these approaches is the only solution to the 40 million uninsured. In fact, I would suggest that because consumer, employer and government based health care plans make up our insured population today and each will continue to be necessary components in an appropriate way of a solution that will make significant progress on toward reducing the number of uninsured.
- The two largest segments of the total uninsured population are the impoverished uninsured and the working uninsured. The impoverished uninsured segment consists of 23 million out of 40 million individuals, 26% of which are below 100% of the Federal Poverty Line (FPL) and 31% at 100-200% of the FPL. The working uninsured comprise 25 of the 40 million. Obviously some of the "impoverished uninsured" are also found in this segment. The largest portion of this population is found among small businesses with less than 25 employees.
- The smaller yet no less critical significant segments of the total uninsured population include unhealthy uninsured and newly displaced uninsured, both comprising approximately 2 million out of 40 million individuals. Although the focus of our discussion today is the broad set of uninsured, it is helpful to identify some of the possible unique solutions needed to address these segments of the uninsured population.
- For the 23 million individuals classified as impoverished uninsured, I was surprised at the number of people below 100% of the FPL that aren't covered by Medicaid. Perhaps Medicaid ought to be available to all individuals under the FPL to guarantee health care coverage to the poorest of the poor. Furthermore, I am eager to work with states to simplify SCHIP eligibility checking with an online approach that we call "Inline with What's Online." Legislative directive and funds for online eligibility verification at the national level can ensure more effective distribution of SCHIP allotments.
- In order to address the larger segment of working uninsured, another place to focus may be the regulations that cause insurers to reject individual coverage for employees receiving assistance from an uninsured employer. Shouldn't small businesses that can't afford to purchase or administer a group plan be allowed and encouraged to reimburse employees to purchase an individual policy? Also, the working uninsured is a rich environment for implementation of tax credits with meaningful amounts to assist with the cost of premiums in the individual market.
- The segment of unhealthy uninsured represents those individuals with preexisting health conditions that cause insurers to deny them coverage. As I learned more about our health care system, I discovered high risk pools which are functioning in 28 states to offer guaranteed access for these "uninsurable" individuals. High risk pools subsidize the premiums for high cost individuals while causing little or no economic disruption to the market. Yet the greatest criticism of these plans is severe underfunding. Perhaps the federal government should assist those states struggling under the financial burden of high risk pools. And perhaps the federal government should be active in helping these pools to develop in the remaining states.

Conclusion

- As the data I have presented today illustrates, while perhaps not the answer for all of the uninsured, we believe a tax credit will allow a large segment of the uninsured to put the cost of a private health insurance policy within easier reach. Yet even as one of its advocates, I remind you that it is only one compo-

nent of a multi-oriented approach to a complex problem of the uninsured. I remember the words spoken to me in a conversation with a senior Senator regarding such complex issues: do the easy things first for incremental progress. If we turn away ideas because they won't solve the problem in its entirety, there is a strong chance no one will be helped. Again, thank you for giving me the opportunity to share these thoughts with you today and for your work on behalf of the uninsured.

Average Single Premiums by Age

	age <18	age 18-24	age 25-34	age 35-44	age 45-64	65 and older (4)	all ages
Average monthly premium per single	$ 102	$ 123	$ 138	$ 182	$ 262	N/A	$ 159
Average annual premium per single	$ 1,226	$ 1,481	$ 1,658	$ 2,178	$ 3,144	N/A	$ 1,908
% of Uninsured population by age	24%	18%	21%	17%	19%	1%	100%
% of U.S. population by age	25%	10%	14%	16%	22%	12%	100%

Modest Deductibles and Co-Pays

Deductible	% of Policies Purchased
$500 or less	43.5%
$501 to $1000	25.9%
$1001 to $1500	7.5%
$1501 to $2000	7.8%
$2001 to $3000	10.0%
Over $3000	5.3%
Total	100%

Co-Pay	% of Policies Purchased
$0	36.7%
$5	0.0%
$10	9.3%
$15	9.2%
$20	20.1%
$25	6.2%
$30	10.7%
$35	4.7%
$40	1.2%
$45	1.8%
Total	100%

eHealthInsurance inc

[An Attachment Is Being Retained In The Committee Files.]

Chairman THOMAS. Thank you very much.
Dr. Butler.

STATEMENT OF STUART BUTLER, PH.D., VICE PRESIDENT, DOMESTIC AND ECONOMIC POLICY STUDIES, HERITAGE FOUNDATION

Dr. BUTLER. Thank you, Mr. Chairman, for the opportunity to testify on the proposal to use refundable tax credits to make, in my view, a real start on the task of eliminating the chronic problem of uninsurance. Drawing from my testimony, I would like to emphasize three points to the Committee.

First, there is a long history of bipartisan support for refundable tax credits as one critical ingredient in the solution for the problem of uninsurance. Several Members of this Committee, as you have mentioned, right across the spectrum, have in recent years supported or introduced bills to enact health tax credits, not just you and Mrs. Johnson, Mr. Chairman, but Mr. Stark, Mr. McDermott, and many others. A bipartisan coalition in the Senate also supports the approach, and of course the President supports it.

To be sure, most Members who have introduced such legislation emphasize it is not the total solution. In particular, they emphasize that steps have to be taken to make group coverage more available to the uninsured. I agree, and have included some suggestions on this in my testimony, and I would be happy to discuss those further when we get to questions. But the bottom line is that there is in fact wide acceptance of tax credits as one critical step toward

a solution, so I urge you to enact that step now and move on to the other steps.

Second, I would urge the Committee to be skeptical about many of the objections to tax credits leveled by critics. The claim that helping the uninsured with a tax credit will somehow cause the meltdown of the employer-based coverage system is especially misplaced. If a tax credit would cause a degree of so-called crowding-out, then of course exactly the same objection can be made against any help to the uninsured, such as allowing uninsured families to enroll in Medicaid or State children's health insurance programs (CHIP). In fact, studies by Professor Gruber and others show that poorly designed Medicaid expansions or State health programs can lead to as much as a one-for-one reduction in private insurance.

The critical task, then, is to design a tax credit, or indeed any form of help to the uninsured, in ways that are least likely to reduce good coverage at the place of work. I urge the Committee to look carefully at the Breaux-Jeffords-Snowe REACH Act in the Senate. Their bill includes an additional smaller credit for workers with employer-based coverage. That provision is designed to remove any incentive for employed workers to try to drop out of their employer's plan. Any tax credit program enacted by Congress also in my view should deny the credit to a worker who drops out of an existing employer-sponsored plan.

Another claim is that the proposed credit is not enough. I do have to agree that a larger credit will have more impact than a smaller credit. Nevertheless, the evidence indicates that the credits being proposed would have a significant impact, enabling many of the uninsured to afford a basic plan. And of course the Federal credits could be supplemented by State assistance. It is also worth noting that many States have artificially raised the price of coverage through unwise coverage mandates, and they should be encouraged to permit less expensive, more basic coverage to be offered.

There remains the need, however, to make affordable group coverage more available to families with poor medical histories. Washington should continue to work with the States to address that. As I mention in my testimony, Congress can help by making such vehicles as association plans and an expanded Federal Employees Health Benefits Plan (FEHBP) available within States. I would note that Mr. Stark's 1999 bill would have made the FEHBP available to the uninsured.

My third and final point, Mr. Chairman, is to urge the Committee to apply what I might call the Enron test to every proposal. What would the proposal mean for the thousands of Enron workers who have just lost their jobs? The Enron test indicates why proposals that would merely subsidize COBRA payments, either directly or with a restricted tax credit, are not the way to go. Such proposals in effect say, "If you are fired, we will help you pay for the health insurance, but only if you get it through the same company that just threw you out on the street."

Mr. Chairman, a tax credit for the unemployed must allow laid-off workers to get insurance that they can afford, and get it through an organization that they can trust. Moreover, let's also remember that 60 percent of low-income families do not even qualify

for COBRA coverage if they are laid off. Restricting help to COBRA coverage would do nothing for them.

Mr. Chairman, it is not often that there is such a broad political support in Congress and the White House for a tax measure that would make such a difference to the daily problems of ordinary Americans facing economic distress. I strongly urge the Committee not to let this opportunity slip by.

[The prepared statement of Mr. Butler follows:]

Statement of Stuart Butler, Ph.D., Vice President, Domestic and Economic Policy Studies, Heritage Foundation

Thank you Mr. Chairman for the opportunity to testify before the Committee on this important subject. My name is Stuart Butler. I am Vice President for Domestic and Economic Policy Studies at The Heritage Foundation. My testimony represents my personal views on the issue of health care reform, and should not be construed as representing any official position of The Heritage Foundation. After decades of debate, there is broad bipartisan agreement that action must be taken to address the problem of the uninsured. There is also a growing recognition that although the traditional employment-based health insurance has in many respects been very successful in achieving good insurance coverage for million of Americans, for many workers that system does not assure stable, continuous coverage. For example:

- **There are very high rates of uninsurance among the employees of small firms.** According to a recent survey by the Kaiser Foundation, while 99 percent of large firms offer insurance, only 55 of firms with fewer than 10 employees do so. Among low-wage workers (defined as those who earned less than $7 an hour in 1996), 45 percent are not offered insurance.[1] One reason for this is that employers trying to offer coverage to very small groups tend to face high administrative costs. According to data collected by the Congressional Budget Office, overhead costs for providing insurance can be over 30 percent of premium costs for firms with fewer than 10 employees, compared with about 12 percent for firms with more than 500 employees.[2]
- **The tax laws effectively force workers to accept coverage from their employers.** The current tax system excludes from taxable income (federal and state income tax, and payroll taxes) all compensation provided in the form of employer-sponsored insurance. The lack of virtually any practical tax relief or similar assistance for the vast majority of workers without such coverage helps explain the high uninsurance rate among employees of smaller firms and those between jobs. The absence of such assistance has also discouraged the growth of insurance offered through large organization with which workers may have along term affiliation, such as their union or their church.

Spurred by these general concerns and by the more immediate issue of families without insurance due to the economic slowdown and the direct effects of September 11th, Congress has three broad approaches before it. Namely:

- **Approach 1: Expand government programs to include millions more working families.** It has always been the goal of some politicians and organizations to achieve a national single payer health system, and this would be a step towards it. But besides the chronic problems besetting Medicaid as well as national systems in Canada, Britain and elsewhere, there is strong resistance to this approach among Americans, as well as within Congress and the Administration.
- **Approach 2: Link any assistance to families remaining with their former employer's plan.** Some proposals, such as that offered recently by the Senate Democratic leadership, would provide assistance to laid-off workers, but only if they continued to purchase coverage under COBRA. This, of course, does nothing for workers without a plan offered by their current or former employer. Moreover, in many cases laid-off workers cannot afford, or do not want, plans offered through their former employer—an employer in many cases who has abandoned them and may be in dire financial straits. Under this approach a

[1] Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: Key Facts* (Washington, D.C.: Kaiser Family Foundation, 2000).

[2] Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (Washington DC, 1994), p. 8.

former Enron worker—who has just lost his or her job and pension—would be told they could get help for insurance but only if they used it to buy coverage through the bankrupt firm that had thrown them onto the street.

- **Approach 3: Offer a refundable tax credit for those for whom employer-sponsored insurance is not a viable or sensible option.** A number of proposals, including one from the Administration, one passed by the House, and plans offered in both chambers by a remarkably bipartisan group of members, would provide a refundable tax credit for the purchase of insurance. These approaches make far more sense. They would allow a parallel "third way" system to develop alongside employer-sponsored and government-sponsored coverage for those Americans who want private insurance but also want the stability and control that comes with a plan chosen by the family and organized through an organization they trust—much as members of Congress are able to do through the FEHBP.

  As important as the technical merits, a tax credit approach is also the most practicable option today precisely because it commands wide support in Congress and the Administration, and so can be achieved. To be sure, design issues need to be addressed and choices made. A refundable tax credit for health insurance can—and should be—enacted by Congress and signed into law by President Bush.

Key Design Issues for a Tax Credit Program

There are several desirable elements for an effective tax credit, especially for laid-off workers and for low-income, uninsured populations

1) Eligibility ideally should include those with employer-sponsored coverage.

Ideally some level of credit should be available regardless of job status—i.e. available to the working uninsured and insured, and to unemployed workers. With a properly designed credit, this eligibility criterion would eliminate any bias against employer-sponsored coverage by providing the equivalent level of help to those with or without that option. I suggest the committee examine Senate legislation offered by Senator Jeffords and others (the REACH Act, S 590). This contains a lower credit for employees with employer-sponsored plans. When combined with the exclusion, this lower credit is designed to provide a level of subsidy for the out-of-pocket costs of insured employees that is equivalent o the full credit available for the uninsured.

2) The credit should be refundable and advanceable.

To be meaningful to lower-income families, refundability is necessary. So is a credit, rather than a deduction, is needed in order that families with low marginal tax rates receive adequate help. A credit also should designed to be available "up front" instead of requiring the family to wait until the end of the year. This can be achieved simply enough through the tax withholding system for employed, tax-paying individuals—in the same way that other tax benefits, such as the mortgage deduction or child care credit, are "advanced." In addition, if the credit can be "assigned" to a health plan in return for a lower premium (much like federal employees receive their government subsidy in the FEHBP), that would make a simple alternative method available for workers who do not file a tax return or do not wish to use the withholding system. Assignment can be organized easily for a fixed or percentage credit with no income phase out. Income adjusted credits pose small complications but can be reconciled through the tax system.

An unemployed person with an assigned credit similarly would face a reduced premium. Alternatively, a tax credit for unemployed workers could be paid through the unemployment insurance system. This would require a funds transfer between the Treasury and the Department of Labor, with the money then distributed to state unemployment offices (similar to the supplemental benefit programs delivered in this way since 1958). The state unemployment offices could take on responsibility for remitting premium payments to insurers. Unemployment offices would be required to inform the unemployed individuals about the tax credit and to provide necessary participation forms. Unemployment offices, which are already responsible for verifying unemployment, would be required to verify worker eligibility for the credit.

3) Different forms of credit will have different impacts.

There are several forms of tax credits, each of which have subtly different effects. One is a fixed dollar credit, as proposed by the President and others, such as Senator Jeffords, Representative Armey, and in 1999 legislation by Representative Stark. This is simpler, making calculation of the after-credit premium cost easy for

the insurer and recipient. Assignment of the credit would also be easy. For a given budgeted amount, moreover, the fixed credit does concentrate the assistance to those most financially needy. On the other hand, individuals with greater health care costs would face 100 per cent of additional out-of-pocket costs if they needed elaborate coverage.

Another approach is a percentage credit, such as that included in the House stimulus package and in legislation offered in the past by several lawmakers, including Representative McDermott. This approach would be more expensive if it also included a minimum at least equal to the fixed credit, but it would help families with higher health care costs by reducing the marginal after-tax premium cost. In addition, by making it more affordable for younger, healthier individuals to purchase more comprehensive plans, it would reduce adverse selection concerns.

Recent unpublished research by Emory University professor Ken Thorpe suggests that there would be very little adverse selection at all with a credit equivalent to the FEHBP subsidy (approximately 75 per cent).

4) Employers may be the best location through which most families get coverage, even though employers are not necessarily the best sponsors of coverage.

Most people in America pay their taxes through a place of work. This is a very convenient system under which employers withhold income and Social Security taxes and send the money to the government. In addition, employees typically adjust their withholdings to take advantage of any tax breaks for which they may be eligible (for example, the mortgage interest deduction). Employers thus facilitate the tax system, but they do not in any sense design or "sponsor" the tax code. They could more appropriately be considered a clearinghouse for tax payments.

The place of employment would also is likewise particularly convenient and efficient for handling health insurance payments. With individual tax credits available, employers who do not currently sponsor insurance could still carry out the critical clearinghouse role for plan choices, tax adjustments, and premium payments. In other words, smaller employers could handle the mechanical aspects of arranging for payroll deductions and premium payments (similar to their role in the tax collection system) without having to sponsor a plan. With individual credits, eligible employees could join any plan available in their area, not just one sponsored by their employer, and still obtain tax benefits. Thus, very small employers could play a very important role in *facilitating* coverage without having to *organize* coverage.

5) Avoid minimum benefits requirements.

Some argue that any tax credit should be conditioned on the eligible family purchasing a health plan with a federally determined comprehensive benefits package. This would be a mistake. A federally mandated comprehensive plan would be very expensive, putting it out of reach for many families, and yet in many cases still would not included certain benefits required by some families (this has, after all, been a constant feature of Medicare). A comprehensive federal benefits package (which would be the ceiling as well as the floor for most lower-income families) would also invite provider lobbying to include often-marginal benefits. This pattern, seen at the state level, could make insurance prohibitive to lower-income families, as the experience of state mandates has demonstrated.[3]

If Congress unwisely insists on a benefits package, it should be for a *minimum* package, primarily catastrophic insurance protection, and not comprehensive coverage. It should also be in the form of broad areas of coverage, such as hospitalization and major medical, similar to the requirements for plans in the FEHBP or the California Public Employees' Retirement System (CalPERS), rather than a precisely defined set of specific benefits, such as Medicare fee-for-service.

6) Washington should work with states to make new forms of groups and intermediaries available as vehicles for insurance.

The individual market does not have to be the only choice for coverage. Indeed, with a tax credit reducing the obstacles to new forms of group emerging, it is likely that other purchasing options—in some cases similar in structure to employer-based coverage—would begin to emerge. This development can be hastened through government action.

Four types of groups are particularly attractive additions to traditional employer-sponsored coverage.

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[3] Melinda Schriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," *Backgrounder* 1211,(Washington: The Heritage Foundation, August 14, 1998).

- **Affinity groups.** Several common institutions in American communities are well placed to serve this function for insurance and as intermediaries negotiating with insurers on behalf of families. For example, ***unions*** as "friendly societies," have had a long history of involvement in health care. In addition, many religious denominations also have a long history of providing insurance services for their congregations. For lower-income African Americans and others, ***churches*** are a far more stable institution in the community than local public health and small employers, and one that has the long-term social welfare of families firmly in mind. These groups acting as insurers themselves, any more than the Mailhandlers union does in the FEHBP, but instead as buying agents that reach agreements with insurance plans that actually shoulder the risk.
- **Associations**. Various employment-related associations have arisen to group people together to obtain insurance without the employer directly sponsoring coverage. These include health purchasing cooperatives and coalitions and multiple-employer welfare arrangements (MEWAs), and they also face strict restrictions at the state level that affect their insurance arrangement and benefits. There have been proposals in recent years to create new kinds of associations that would be free from many state restrictions, particularly state benefit mandates.
- **The Federal Employee Health Benefits Program (FEHBP).** While technically an employer-based system, the FEHBP actually serves the equivalent of a small country (with nearly 10 million covered individuals) and offers a broad choice of plans. While a federal worker's immediate employer does not sponsor plans, the place of employment is still the "entry point" for selecting plans. FEHBP plans are regulated at the federal level, through a combination of general statutory and administrative regulation supplemented by a process of negotiations between the Office and Personnel Management, on behalf of the federal government, and plans wishing to market through the FEHBP. There have been several proposals to open up the FEHBP to non-federal workers under various conditions, typically using a separate insurance pool. On a small scale, this model could be implemented by states using their state employee plans.
- **Large corporate health plans available to non-employees.**

  Tax credits to individuals would remove the current tax barrier to large corporations' marketing their health plans widely to non-employees. This could mean major and attractive new options, especially for the uninsured and for the workers employed by very small firms.

  It is quite common for large firms to take products developed initially as an internal service to the firm and market them to external customers. For example, General Motors formed the General Motors Acceptance Corporation (GMAC) out of its huge automobile loan service and markets a broad range of financial services to non-employees. It is even possible for people with no connection to General Motors to finance their house with a mortgage from GM. But this does not happen with health insurance, principally because the tax code provides no tax benefits to families buying health insurance from a corporate plan that is not their employer

  An individual tax credit would remove this obstacle, allowing families to join any health plan while claiming the credit. This would dramatically change the incentives in the current market, opening up a potentially large new market for existing corporate plans and an opportunity for many working families to obtain coverage under these plans.

  One firm whose activities hint at what could happen in a more liberalized environment is the John Deere Company. Intent on improving the health care of its own employees while reducing costs, the company several years ago created its own Health Maintenance Organization (HMO). It then began to offer coverage to other employers and purchased health operations to serve its new market. The company, however, has not confined itself to offering its expertise and facilities only to employer groups. Its for-profit health division, John Deere Health Care, also has offered coverage to individuals as a Medicare HMO and provides managed care Medicaid services in several states. The Deere Plan is also available to some federal workers under the FEHBP. Out of more than 400,000 enrolled in Deere plans in the Midwest and Southeast, less than 20 percent are John Deere employees. The tax code, however, makes it very uneconomic for Deere to offer coverage to groups of working families (except federal workers) other than through their employer.

The federal government should work with the states to foster new forms of purchasing arrangements, in addition to the high-risk pools and other vehicles already being for high-risk individuals. To do this, Congress could enact legislation to permit a range of new kinds of groups, such as opening the FEHBP system to groups of the uninsured in each state, and new forms of purchasing groups. The federal government could then enter into discussions with each state to create a federal-state package of new forms of group insurance, selected from a "menu" of the federal options combined with state measures.

Problems with Other Approaches

Some alternative proposals before Congress would do not adequately provide targeted assistance for the low-income, uninsured populations. Among them:

- **Medicaid/SCHIP expansion.** Extending Medicaid eligibility for the uninsured population raises a number of concerns. For one thing it segregates the uninsured population further from the rest of society with private coverage. Over 85 percent of the uninsured are in working homes. It makes little sense to require these families to seek coverage from a welfare program rather than to help them afford coverage they prefer. Moreover, if the family income rises and they become ineligible for Medicaid, there would be another break in coverage. And further, states are already facing severe budget shortfalls. Some 37 states overspent their Medicaid budgets in FY 2001, and this year Medicaid is already over budget in 23 states according to a survey of state budget officers.[4] States are looking to keep health costs down, not burden themselves financially by expanding eligibility.
- **COBRA-only subsidies.** Subsidizing *only* COBRA coverage, through direct subsidies or a tax credit, raises several problems. First, many unemployed workers, especially low-income workers, do not qualify for COBRA. Some 42 million unemployed workers are ineligible for COBRA and 60 percent of low-income families do not qualify.[5] Second, it would give many families only the "choice" of a still-unaffordable comprehensive plan when their economic conditions would make only a leaner plan affordable even with a subsidy. And third there is the "Enron problem." It makes little sense to condition a subsidy on remaining in coverage organized by the former employer who fired the worker and has no other connection to the family, and who may also be facing severe financial problems that could lead to coverage cutbacks.
- **Subsiding the employer.** Some proposals see to expand coverage by subsiding employers who offer coverage. But this would be like pushing on a string. Credits or other subsidies for employers do not make small firms turn into good risk pools. Even though a subsidy would help to offset the high administrative costs borne by small employers, it would not make administration more efficient or sophisticated, nor would it likely lead to a choice of plans. A subsidy would also not deal with the "hassle factor" that causes so many small-business owners to compete for workers by giving them cash instead of complex benefits.

Two Common Criticisms

Critics of tax credits raise a number of arguments, two of which are widely heard:

Argument 1: The proposed credit is not sufficient to afford coverage and so the take-up rate would be low.

To be sure, a large tax credit would make insurance affordable to more families than a small credit would, just a public program with a large budget would cover more people than one with a small budget. If Congress were to raise the budget devoted to a tax credit program it would certainly be more effective. But there are good reasons to believe that the Administration and Hill proposals for credits would have a significant impact on the uninsured.

First, the individual market may not be as inaccessible as perceived. An E-Healthinsurance survey shows that there are quite affordable coverage options available in most states, especially those who do not impose a high level of mandated benefits.

Second, a federal tax credit should be considered a foundation upon which other financing bricks are added. Put another way, a $3,000 federal credit puts the family $3,000 closer to obtaining affordable coverage. Under current law, and with waivers

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[4] *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001 and 2002*, (Washington DC, Kaiser Family Foundation, 2001), p. 12

[5] Michelle Doty and Cathy Schoen, Maintaining Health Insurance During a Recession: Likely COBRA Eligibility (New York, NY: The Commonwealth Fund, 2001), p. 2

from the federal government, state governments can provide families with SCHIP and other funds to subsidize the purchase of private coverage. The federal government should combine a tax credit program with an aggressive waiver initiative designed to complement the federal credits. In addition, if workers could join large pools utilizing a credit, many small employers in a competitive labor market would have the incentive to make contributions on behalf of their employee's coverage as well, especially those employers who do not offer coverage because of the administrative cost.

Third, the take-up rate of coverage is likely to be greater than some estimates, even at the credit levels now under discussion. A recent study by Pauly and Herring, for instance, estimates that a fixed tax credit equal to 50 percent of the cost of a standard plan would lead to a 48 percent reduction in the number of uninsured.[6] Determining the take-up rate is difficult—as it is with, say, expansions of Medicaid. Two contributing factors are illustrative. If alternative government programs (and emergency room care) is inexpensive to families, this has the effect of "crowding out" tax credit-subsided coverage, leading to lower take-up rates. But if these alternatives are less available or more costly the take-up rate would be much higher. The ease of obtaining the subsidy and signing up for coverage is also a significant influence. With assignment and automatic enrolment at the place of work, take-up rates likely would be quite high. Evidence from pension plans indicates that an automatic enrollment system for health insurance could have dramatic effects on sign-up rates.[7]

Argument 2: A credit would "crowd out" traditional employer-sponsored plans.

Some critics maintain that providing a tax subsidy to the uninsured is inefficient because many employers currently providing insurance would drop their employees' coverage.

The simplest response to this charge is that it applies, of course, to *any* proposal to help the uninsured, including expansions of public programs. Indeed, there have been a number of studies of "crowd out" in Medicaid and other programs, and these indicate a significant substitution effect. Cutler and Gruber, for instance, found a range of crowd out effects for Medicaid expansions in the late 1980s and early 1990s, depending on exactly what was measured. The decline in private coverage, as a share of the persons who enrolled in Medicaid directly as a result of the expansions was as much as 50 percent.[8] A new study of state-based expansions of coverage, by Kronick and Gilmer, indicate a variety of crowd-out effects depending on the design of the program. Oregon and Washington, for example, reduced uninsurance with very little crowding out of private insurance, while in Tennessee almost half of the increase in publicly covered individuals resulted from a decline in private coverage. In Minnesota almost all the enrollment in the new public plan "was accompanied by a decline in the number of privately insured persons and virtually no change in that of uninsured persons."[9]

The answer is not to do nothing, of course, but to recognize that tax credits are no different from other approaches in having some substitution effects. In some cases substitution is actually desirable. It is beneficial, for instance, if it means workers using a tax credit can obtain permanent coverage through a large non-employer group, rather than using the tax exclusion to obtain impermanent coverage through a small employer that does not meet their needs is very costly. Steps should be explored to reduce unwelcome crowding out, however. The smaller credit available in the Jeffords REACH act for individuals with employer-sponsored coverage likely would reduce crowding out, for instance. In addition, it would be wise to include a prohibition against workers dropping out of an employer-sponsored pool and claiming the credit—not just to discourage crowding out but to prevent the employer's risk pool being undermined.

In conclusion, it is vital that Congress seizes the opportunity before it to make a real down payment on helping the uninsured through a mechanism that has

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[6] Mark Pauly and Bradley Herring, "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes," *Health Affairs*, volume 20, no. 1, January/February 2001, p. 16

[7] A recent study found that automatic enrollment for 401(k) plans boosted participation rates from 37 percent to 86 percent for such voluntary pensions, with even sharper increases for young and lower-paid employees. See Brigitte Madrian and Dennis Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, National Bureau of Economic Research *Working Paper* No. 7682, May 2000, p. 51.

[8] David M. Culter and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, volume 16, no. 1 (January/February 1997) pp. 194–200.

[9] Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?" Health Affairs, volume 21, no. 1 (January/February 2002), p. 235.

strong support in each chamber and in the White House. A tax credit for insurance not provided through the place of employment is a sensible step that Congress could take this year, while it also take steps to improve the availability of group coverage throughout the states. Taking this step would be consistent with the objective shared by both conservatives and liberals of achieving a health system in which a family's access to health care and coverage, and the help they get to afford care, does not depend on where they work.

Chairman THOMAS. Thank you very much. Ms. Lav? The mikes are very unidirectional, so you probably need to get fairly close to it and talk directly into it.

STATEMENT OF IRIS LAV, DEPUTY DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES

Ms. LAV. Thank you. Thank you, Mr. Chairman. I am Iris Lav, Deputy Director of the Center on Budget and Policy Priorities. The Center is a nonprofit policy institute here in Washington that specializes in both fiscal policy and in programs and policies affecting low- and moderate-income families, and I appreciate the invitation to be here today.

My testimony largely focuses on the Bush Administration's proposal to provide a refundable tax credit to families and individuals who do not participate in employer-based coverage for the purchase of private health insurance. We welcome the Administration's commitment of significant resources to insurance coverage, but we view a tax credit as the wrong approach for solving the problems of the uninsured.

There are three major problems: the weakening of the employer-based system through which the large majority of insured Americans currently obtain quality health insurance coverage; the vagaries of the individual insurance market for anyone except the young and healthy; and the inadequate size of the credit relative to the cost of insurance for low- and moderate-income families. None of these problems can be solved in the context of a tax credit approach without causing other problems or taking actions that I think all of us would agree are not politically feasible.

First, the tax credit would lead some employers to drop or not offer coverage. Employers will feel that employees can use the credit to buy coverage on their own. The credit also will draw younger, healthier workers away from employer coverage into the individual market. This leaves older, sicker workers in employer insurance pools, driving up the average cost of coverage. In response, employers will raise employee contributions, leading more younger, healthier workers to opt out. This insurance death spiral, in which employers ultimately cannot afford to offer insurance, would leave older and less healthy workers to find insurance on the individual market.

The nature of this individual market is the second problem. In the individual market, insurers generally can vary premiums based on age and medical history and can deny coverage altogether, yet many of the uninsured are in the very categories for whom insurance in the individual market is unavailable or prohibitively expensive. Over half of all uninsured adults have a history of serious medical conditions such as cancer, heart disease, and diabetes, or

they smoke, or they are obese. Moreover, two-thirds of lower income uninsured adults above age 50 have been diagnosed with a chronic condition. So, you know, when you look at the CEA data, they are talking about the cost for a healthy person. They are not talking about these people who are uninsured.

The third issue is whether the proposed tax credit can make insurance affordable for the populations that it is intended to reach. A healthy family of four with income of $25,000 that receives a $3,000 tax credit would have to spend more than 17 percent of the family's gross income to purchase a mid-range policy on the individual market.

One might consider ways to fix these tax credit problems, but unlike some of my colleagues, I don't think such fixes are practical. For example, one could mandate employers to offer or administer insurance, or mandate States to implement reforms in the individual market, but that is probably not in the cards.

Moreover, a tax credit is highly inefficient. Professor Jon Gruber of M.I.T., who has been discussed greatly this morning, did look at this proposal in testimony submitted for this hearing, and found that 10.5 million people would take up the Administration's tax credit, but because of employers dropping and employees switching, the net reduction in the number of uninsured ends up being only 1.9 million out of that 10.5.

What is a better approach? Expand the programs we already have in place for low- or moderate-income populations, where the bulk of the uninsured are. A number of States already have expanded to include parents, and some include other adults, under SCHIP, and others would do so if funding were provided. This approach provides quality insurance that does not exclude people with medical problems.

Finally, I would like to say a few words about the proposals to cover workers who have become uninsured in this economic downturn. The House stimulus proposal for a tax credit for unemployed individuals eligible for unemployment insurance, that they could use to either purchase COBRA or health insurance in the individual market, raises some of the same questions with respect to the individual market.

Consider a 55-year-old laid off construction worker who worked for a company too small to offer COBRA. If he has a history of heart problems, he probably would not be able to use the tax credit to access insurance in the individual market, and certainly not at an affordable price. And there would be no help under the proposal for those not eligible for unemployment insurance, which includes a lot of low- and moderate-income people.

A better approach would be to provide a deeper COBRA subsidy coupled with a largely Federally paid option for States to cover unemployed workers under Medicaid. This would provide quality insurance, either employer-provided or the comprehensive Medicaid benefit, regardless of age or health status. It also would be likely to cover more workers than the House plan. The Congressional Budget Office estimates 7 to 9 million workers could be covered, depending on the Federal Medicaid matching rate.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Lav follows:]

Statement of Iris Lav, Deputy Director, Center on Budget and Policy Priorities

I appreciate the invitation to testify today. I am Iris Lav, deputy director of the Center on Budget and Policy Priorities. The Center is a nonprofit policy institute here in Washington that specializes both in fiscal policy and in programs and policies affecting low- and moderate-income families. The Center does not hold (and never has received) a grant or contract from any federal agency.

My testimony today largely focuses on the Bush Administration's health insurance coverage initiative in the fiscal year 2003 budget: a proposal to provide a refundable tax credit for the purchase of private health insurance to families and individuals not covered by employer-based coverage. This proposal would cost $89 billion over 10 years and would account for the vast majority of the new resources the Administration is proposing in the health insurance coverage area.

While we welcome the Administration's commitment of significant financial resources to provide assistance to the 39 million Americans without health insurance, we view a tax credit as the wrong approach for solving the problems of the uninsured. The Administration's tax credit proposal suffers from a number of significant flaws, including likelihood that it will materially weaken the employer-based health system through which the large majority of insured Americans currently obtain quality health insurance coverage. While it might be possible in theory to design a tax credit that would better address this and other concerns about the Administration's proposal, it is highly unlikely that such a tax credit would be politically viable at this time because it would require some combination of mandates on employers to offer insurance, states to reform individual insurance markets, and/or individuals to remain in employer-provided insurance.

This testimony also suggests that there is a superior alternative to a tax credit in covering the uninsured: an expansion of Medicaid and the State Children's Health Insurance Program (SCHIP).

In addition, a section of this testimony addresses approaches to helping the unemployed maintain health insurance during the current economic downturn. Subsidizing the purchase of COBRA insurance would help maintain coverage for substantial numbers of unemployed people who otherwise could not afford to pay the pay the COBRA premiums. A tax credit for purchase of insurance in the individual market would be of limited help to low-income or older and sicker unemployed workers. Moreover, if such a credit were extended beyond the unemployed, it would post the same risks as the Administration's plan.

Finally, the appendix to this testimony addresses another health initiative in the Administration budget that, like the health insurance tax credits, threatens to undermine employer-provided insurance. This is the proposal to expand Medical Savings Accounts.

Tax Credit for the Purchase of Health Insurance in the Individual Market

The Administration is proposing to provide a refundable tax credit to individuals and families not participating in employer-based health insurance or public health insurance.[1] Families with two or more children could receive a tax credit of up to $3,000 annually to pay for health insurance primarily in the individual market, so long as the subsidy does not exceed 90 percent of the premium cost. Individuals could receive a credit of $1,000. (The tax credit also could be used for individual health insurance purchased through private purchasing pools or state high-risk pools where such pools exist). The credit would not be available to families with incomes above $60,000, and the subsidy would begin to phase down once a family's income reached $25,000. (Similarly, individuals making $30,000 would not be eligible for the credit, with the subsidy beginning to phase out when an individual's income reached $15,000.)

Under the proposal, the credit could be issued in advance (rather than waiting until a family or individual filed a tax return after the year was over); insurers would reduce the premium cost by the size of a family's credit and be reimbursed by the Federal Government. States would also have the option of letting certain tax credit recipients purchase coverage in their Medicaid or SCHIP managed care plans (or through their state employees' health plan if no managed care plans are available), but there would be no requirement that states do so.

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[1] U.S. Department of Treasury, *General Explanations of the Administration's Fiscal Year 2003 Revenue Proposals* (February 4, 2002), p. 18-21.

Likely Weakening of the Employer-Based Health Insurance System

The principal concern with the Administration's tax credit proposal is that the availability of the tax credit could lead some employers to cease providing coverage to their workers and induce new employers not to offer coverage.

Analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute all have written that enactment of a tax credit of this design (open to individuals currently eligible for employer-based coverage) could encourage firms not to offer health insurance coverage to their employees because firms would know their workers could now get a tax credit to purchase coverage in the individual market.[2] For example, new research by Professor Jonathan Gruber at M.I.T. shows that the Administration's proposal would draw four million people out of employer-provided insurance. Gruber's research shows that 2.4 million people would be dropped from group insurance by their employers—one million of which will move to nongroup insurance and 1.4 million of which will become uninsured. Overall, the research shows that for every person gaining insurance under this proposal, two persons will be leaving the group insurance market.

Substituting the purchase of health insurance in the individual market for group coverage through an employer is particularly troublesome. It could seriously disadvantage older and less healthy workers, many of whom would not be able to obtain coverage or could obtain coverage only at exorbitant costs. In most states, insurers can vary premiums for health insurance policies offered in the individual market on the basis of age and medical history and can refuse to cover people entirely. If employers that otherwise would offer coverage decline to do so because of the availability of a tax credit of this nature, the consequences could be serious for many older and less healthy workers, who generally would have to pay far more than the tax credit would provide to secure coverage in the individual market. Moreover, the individual market often denies insurance entirely to people with certain health conditions.

Aggravating this problem is the fact that under the Administration's proposal, some workers whose employers do offer coverage and ask their employees to pay a share of the premium could opt out of employer-based coverage and use the tax credits instead to purchase insurance in the individual market. Such a move could be attractive to young, healthy employees. These young and healthy workers could have a double advantage. Because they are a low risk, the policy they could buy in the individual market may be cheaper than the average cost of the employer-provided coverage, especially if they choose more limited coverage. In addition, if the tax credit covers 90 percent of this cheaper coverage, the tax credit subsidy may be larger than the premium subsidy their employer provides. Thus these young and healthy workers could find it financially advantageous to opt out of employer coverage and move into the individual market. Professor Gruber's research indicates that approximately 1.5 million persons would voluntarily switch from their group policies to nongroup policies.

But if these workers—largely those who would get the lowest cost policies in the individual market—opt out of employer coverage, the pool of workers remaining in employer plans would become older and sicker on average, which in turn would drive up the costs of employer-based insurance. This phenomenon is known as "adverse selection." Once adverse selection starts and the cost of employer-based insurance begins to rise, additional younger, healthier workers would be induced to abandon employer-based coverage and use their tax credit instead, because they now could personally do better in the individual market using the tax credit.

In this way, a vicious cycle—sometimes called an insurance death spiral—could be set in motion. The increase in premiums for employer-based coverage that ultimately could occur could induce many employers either to cease offering health insurance or to increase substantially the amounts their employees must pay for insurance. The end result would likely be that many older and less healthy individuals would eventually lose their employer-based coverage and become uninsured or underinsured or have to pay exorbitant amounts for decent coverage.

Intensifying the risk that many firms might not offer coverage is the recent return of a high rate of inflation in health care costs, which are now rising at double-digit

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[2] Jonathan Gruber, *Tax Subsidies for Health Insurance: Evaluating the Cost and Benefits,* National Bureau of Economic Research (February 2000); Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance*, Kaiser Family Foundation (October 1999); Leonard E. Burman and Amelia Gruber, *First Do No Harm: Designing Tax Incentives for Health Insurance*, National Tax Journal (May 2001); Linda Blumberg, *Health Insurance Tax Credits: Potential for Expanding Coverage*, Urban Institute (August 2001).

rates in many areas. Institution of the tax credit could provide a rationale for some employers seeking to cut costs to drop or not to institute coverage.

On balance, M.I.T. professor Jonathan Gruber finds that 10.5 million people would take up the credit. Of those, roughly one-third, 3.3 million people, would have been uninsured. But because the credit would cause a lot of churning in employer-provided insurance, some people become newly uninsured. The net reduction in the number of uninsured is only 1.9 million people.[3]

Some tax credit supporters have argued that additional changes to this type of tax credit could lessen the likelihood that the tax credit would weaken the employer-based health insurance system. For example, the credit could be limited only to those persons not currently eligible for employer-based coverage. Changing the design in this way would not, however, eliminate the incentive for employers to drop existing coverage. Employers that know their workers can turn to a tax credit to obtain coverage in the individual market may be more reluctant to offer coverage. In addition, it is difficult to imagine how a credit limited to those *not eligible* for employer-provided health insurance could be administered. It would require the Internal Revenue Service to determine whether a person is eligible for insurance through their employer or their spouse's employer. Administering such a credit would require massive new reporting requirements for employers and an entirely new—and arguably inappropriate—burden for the IRS.

Going in the opposite direction, one could say the credit could be used by employees to pay for their contribution to the cost of health insurance. Such a proposal could help uninsured employees who are offered insurance but cannot currently afford their premiums obtain coverage through their employers. However, these credits could also encourage firms to lower their contributions, and thereby substitute public money for employer contributions. Since a "maintenance of effort" requirement for employers would not be popular and would be impossible to administer, employers—rather than the employees for whom insurance is not affordable—could reap the benefit of such a credit.

There is a design of a tax credit that arguably could avoid the type of damage to the employer-based system discussed above. It would include a mandate on employers to offer coverage—so employers would not be tempted to drop coverage—and a mandate on individual workers with employer-based coverage to use their tax credit solely for the purchase of insurance through their employer's group—so healthy employees would not opt out of employer coverage to save money. Such requirements certainly are not politically feasible. Moreover, they would result in the substitution of public funds for employer contributions and thus would constitute a *much* more expansive, and costly, credit than the Bush Administration has proposed.

Limited Access in the Individual Market

The Administration envisions that most tax credit recipients would primarily use the credit to purchase health insurance in the individual market. However, many of the uninsured face significant barriers to obtaining insurance in the individual market. More than one quarter of all uninsured adults suffer from serious medical conditions such as cancer, heart disease and diabetes and over half (53 percent) have a history of serious medical conditions, smoke, or are obese.[4] One quarter of non-elderly uninsured adults are over 45 and among lower-income uninsured adults above age 50, some 39 percent reported a limited disability and 66 percent had been diagnosed with a chronic condition.[5] All of these are people for whom insurance in the individual market is either expensive or unavailable. By contrast, only a small segment of the uninsured population, 15 percent, are young adults ages 19–34 who do not have children and lack problematic health conditions.[6]

As noted, these sicker and older individuals who constitute such a large percentage of the uninsured likely would be unable to access adequate health insurance in the individual market without paying exorbitant amounts. This is because the individual market is generally unregulated. The individual market generally permits individual medical underwriting, that is insurers can vary premiums based on age and medical history and can deny coverage entirely. For example, according to the

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[3] Jonathan Gruber, Written Testimony before the House Ways & Means Committee (February 13, 2002).

[4] CBPP analysis of Health Interview Survey, 1997.

[5] U.S. Census Bureau, *Health Insurance Coverage: 2000* (September 2001); Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, *Market Failure? Individual Insurance Markets for Older Americans*, Health Affairs (July/August 2001).

[6] CBPP.

Commonwealth Fund, only 16 states require that insurers provide a plan to most applicants—and that does not necessarily mean an affordable plan.[7]

A recent Kaiser Family Foundation study used hypothetical families and individuals to apply for coverage in the individual health insurance market (the hypothetical applicants were structured to test the medical underwriting process through 60 applications in eight geographic markets). The study found, as expected, that older and sicker people are often unable to obtain coverage in the individual market.[8] This means that under the Administration's proposal, a family containing older or sick members could find itself excluded from coverage or charged premiums that are unaffordable, even with a tax credit. Alternatively, such a family could be offered a plan that is affordable but does not provide coverage for a variety of medical conditions. For example, the Kaiser study used the hypothetical "Crane" family, consisting of two adults and two children. In this family, while one child, "Cindy," is in excellent health, the older brother, "Colin," has asthma. The family received an offer of insurance under each application in every market but 15 percent of the offers excluded coverage of Colin entirely and more than half excluded coverage of Colin's asthma.

In addition, many plans in the individual market do not offer comprehensive coverage required by older and sicker families and individuals. For example, they may require high deductibles of $1,000 or more and may not cover maternity care, preventive benefits, and mental health services. Others may set limits on prescription drug coverage.

The Administration purports to respond to this concern by allowing tax credit recipients to buy coverage through high risk pools as well as other private purchasing pools. However, according to the Commonwealth Fund and other researchers, the success and scope of these mechanisms has been limited.[9] While more than half the states operate high-risk pools, participation is low—only 105,000 people participated in 1999. Such pools also often impose high premiums, deductibles and other cost-sharing that limit affordability and may provide limited benefits (for example, excluding mental health and maternity care or capping prescription drug costs). Participants may also face a preexisting condition exclusion for some period of time.

The Administration also suggests that that certain low-income individuals would be permitted to use their tax credits to buy into comprehensive public coverage. It is uncertain how many states would elect this option and open their Medicaid and SCHIP managed care plans to tax-credit recipients. Furthermore, the persons most in need of these buy-ins to public coverage are sicker, high-risk individuals who cannot otherwise obtain coverage in the individual market. Adding these individuals to the current Medicaid and SCHIP managed care risk pools (which currently tend to include healthier families and children, rather than the elderly and disabled who cannot be enrolled on a mandatory basis in managed care), could raise Medicaid and SCHIP costs significantly.

Alternatively, reforms to the individual health insurance market could be added to the Administration's tax credit proposal. In other words, the federal government could mandate that states enact certain insurance reforms to ensure access for tax credit recipients including: guaranteed access (insurers have to offer coverage to all applicants), minimum benefits (all plans provide at least some standard comprehensive coverage), and community rating (premiums cannot vary by age, medical history, or both or can vary only within certain limits). While some states have adopted some of these market reforms, it seems politically unlikely that the federal government at this time would require all states to take these steps.

Inadequate Size of the Tax Credit

The tax credit is of inadequate size to make health insurance affordable for many low- and moderate-income families. Health insurance can be expensive. According to the General Accounting Office, the mid-range premium for family insurance in the non-group market exceeded $7,300 in 1998.[10] Nevertheless, even without factoring in the increases in health insurance premium costs since 1998 for the GAO estimate, a family of four with income of $25,000 that receives a $3,000 tax credit

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[7] Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*, Commonwealth Fund (August 2001).

[8] Karen Pollitz, Richard Sorian and Kathy Thomas, *How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?*, Kaiser Family Foundation (June 2001).

[9] Achman and Chollet. *See also* Sally Trude and Paul B. Ginsburg, *Tax Credits and Purchasing Pools: Will This Marriage Work?*, Center for Studying Health System Change (April 2001).

[10] U.S. General Accounting Office, *Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990*, GAO/HEHS-00-104R (April 2000).

would have to spend $4,300 in health insurance premiums ($7,300 minus $3,000). That would constitute more than 17 percent of the family's gross income to purchase insurance at this price. The family would have additional out-of-pocket costs for deductibles and co-pays before they could receive any benefit from having the insurance.

Similarly, the Commonwealth Fund looked at premiums for relatively comprehensive individual health insurance with a $250 deductible for a single healthy adult age 60 in 15 cities. The median annual premium was $5,688.[11] Even with a tax credit of $1,000, a 60 year-old with income of $15,000 would still have to pay over 30 percent of his gross income to obtain insurance. Of course, a less healthy person is likely to pay even more, if they are not excluded entirely from the individual market. Furthermore, in some high-cost geographic areas, higher premiums could consume still-greater percentages of family income. Studies indicate that such expenditure levels are beyond what most low- and moderate-income families can afford.

Some supporters of the Administration's tax credit proposal may argue that family coverage in the individual market is far more affordable than GAO determined. According to a study by an online health insurance broker, the average premium cost was estimated to be between $3,600 and $4,500 for families of three who have *actually* obtained coverage in the individual market through the broker.[12] That average, however, is likely to have been skewed downward considerably by the better risks associated with younger, healthy individuals who are most able to access insurance in the non-group market as well as the potentially less generous benefits provided. For example, this average is not the average premium offer made; applicants that turned down the offer of health insurance because it was too expensive would not be factored into the average cited by the study. (And it does not indicate the number of applicants who were denied coverage entirely.)

One could argue that the problem could be solved by increasing the size of the credit. Increasing the size of the credit, however, involves a trade-off. While a larger credit could make health insurance in the individual market more affordable for some tax credit recipients, it also would intensify the likelihood that the adverse effects on the employer-based system would occur. This is because a larger credit would make it more attractive for employers to cease offering health insurance coverage, as well as increase the probability that young, healthy individuals would prefer to leave employer-based coverage.[13]

Continued Timing Problems for Advance Payment of the Credit

A number of studies have pointed out that to be effective—especially for low- and moderate-income families—the credit must be available at the time the insurance premiums are due rather than at the end of the year when taxes are filed. Low-income families on tight budgets would have difficulty paying health insurance premiums during the year and then waiting until the tax filing season in the following year to be reimbursed through a tax credit.[14] The Administration proposes to address this timing problem by permitting advance payment of the tax credit. Insurers would discount premiums paid by tax credit recipients and be reimbursed for the discount by the federal government. Eligibility for the advance credit would be based on the taxpayer's prior year tax return.

There is a drawback to basing eligibility for an advance credit on the prior year's tax return. The incomes of low- and moderate-income families fluctuate significantly during the course of a year due to changes in family situation, job losses or changes, overtime pay and other variables. Consider a taxpayer with prior year income that is too high to qualify for the credit this year. This year, his work hours are reduced considerably with the result that he no longer qualifies for health insurance coverage through his employer. His income has declined sufficiently to be eligible for the tax credit, but he is not eligible for the advance credit. Since he likely has many obligations to meet with his reduced income, he is unlikely to be able to purchase health insurance and wait for a reimbursement at the end of the year. He probably would remain uninsured.

Alternatively, one could base eligibility for advance payment of the credit on this year's income. This creates a different set of problems. A person could purchase insurance using an advance payment now, but later in the year find that increases in income have made him ineligible for the credit based on his annual income. If

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[11] Simantov.

[12] eHealthInsurance, *The Cost and Benefits of Individual and Family Health Insurance Plans* (June 2001). Based on the study's cost-per-member-per-month estimates.

[13] Burman.

[14] Blumberg.

a reconciliation process is then required at tax time, this person would owe—up to $3,000—to the IRS. Based on experience with advance payment of the Earned Income Tax Credit, fear of owing money to the IRS at tax time would likely deter most families from using the advance payment option. Without the financial resources necessary to pay for premiums up-front, such families would not benefit from the tax credit.

Lack of Cost Effectiveness

In addition to the significant concerns with the tax credit proposal, as discussed above, the tax credit proposal is not likely to be a cost-effective way to reduce the ranks of the uninsured, since the large majority of those who would use the credit are expected to already have insurance. Analysts from M.I.T. and the Kaiser Family Foundation have estimated that under somewhat similar tax credit proposals, more than two-thirds of those using the tax credit would be people who already were insured.[15]

For example, as noted above, Jonathan Gruber of M.I.T. projects that 10.5 million persons would take up the Administration's tax credit. On its face, this appears to be a large population receiving assistance through the tax credit. However, only 3.3 million people would have been previously uninsured; more than two-thirds of tax recipients would have already had insurance. In addition, under his estimates, employer dropping would cause 1.4 million people formerly with employer-based coverage to be unable to find coverage and become uninsured. The net reduction in the number of uninsured ends up being only 1.9 million (which constitutes only 18 percent of the total number of recipients).[16]

As a result, relatively little of the benefit of the credit would go to reducing the ranks of the uninsured. Instead, a large share of the credit's substantial cost would go either to provide people who already are insured in the individual market with a tax cut or to shift people from their current insurance arrangements (primarily through employer-sponsored coverage) to different insurance arrangements.

A Better Alternative: Expansion of Public Programs

As I have discussed, the tax credit proposed by the Administration could threaten the stability of the employer-based health insurance system through which the overwhelming majority of Americans obtain coverage. In addition, the tax credit would favor young, healthy families and individuals over older, sicker persons who most need comprehensive and affordable health insurance coverage.

An effective alternative that avoids these pitfalls is an expansion of the State Children's Health Insurance Program (SCHIP). For example, bipartisan legislation introduced in this Congress would provide $50 billion in new SCHIP funds to states to expand Medicaid and SCHIP coverage to the low-income parents of children eligible for those programs. In 2000, some 34 percent of parents—6.9 million—in families with incomes below 200 percent of the poverty line ($29,260 for a family of three) were uninsured. This is partly the result of limited coverage within the Medicaid program; the Medicaid income eligibility level in the median state is only 69 percent of the federal poverty line (about $10,000). Just as SCHIP facilitated coverage expansions for low-income children, additional federal SCHIP funds could be provided for states to expand Medicaid and SCHIP coverage to parents. While suffering from a slow start, the SCHIP program is now highly successful. As the Department of Health and Human Services announced last week, a total of 4.6 million children were enrolled in SCHIP last year which constitutes a 38 percent increase from 2000 (3.3 million children were enrolled in fiscal year 2000).[17]

A number of states such as Arizona, California, New Jersey, Rhode Island, and Wisconsin have already used SCHIP to expand coverage to parents, as well as other adults. However, the ability of states to continue to expand coverage, as the Administration has urged states to do, is threatened by a lack of sufficient SCHIP funding. The Balanced Budget Act of1997 instituted a 26 percent reduction in federal SCHIP funding for the fiscal years 2002, 2003 and 2004—a reduction of over $1 billion each year. Because of this reduction, in the Administration's budget, OMB projects that SCHIP enrollment will decline by 900,000 people, mostly children, between 2003 and 2006.[18] While the Administration has appropriately proposed to extend SCHIP funds scheduled to expire in the next two years which will help delay or avert some

[15] Gruber, Written Testimony; Feder et al.; Memorandum from Joint Committee on Taxation to the Senate Finance Committee (September 13, 2001).

[16] Gruber, Written Testimony.

[17] Centers for Medicare and Medicaid Services, "The State Children's Health Insurance Program Annual Enrollment Report" (February 6, 2002).

[18] Office of Management and Budget, *Analytic Perspectives* (February 4, 2002), p.297.

of these enrollment declines, it is likely states will have insufficient funding over the long-term to further expand coverage. As a result, states need additional funding under the SCHIP program. This public expansion proposal would provide a number of advantages:

- A public expansion will not substantially encourage individuals to drop employer-based coverage, nor will it induce employers to no longer offer health insurance to their workers—especially as compared to the likely effects of the Administration's tax credit proposal. Research has found that only a modest percentage of the additional individuals covered through public expansions had employer-based coverage.[19] For example, an examination of Minnesota's Medicaid expansion to adults and children found that only seven percent of enrollees gave up private insurance (both employer-based and individual market) to join the program, of which less than half previously participated in employer-based coverage. In Wisconsin, which expanded coverage to parents up to 185 percent of the federal poverty line through its BadgerCare program, only 6 percent of the 25,000 families screened had access to employer-based coverage prior to enrolling in the SCHIP program..
- The coverage will be accessible and affordable to the populations served. Unlike the individual health insurance market, public programs are open to any eligible individual irrespective of their age or medical history. In addition, both the Medicaid and SCHIP programs have limits on premiums, deductibles and cost-sharing to ensure that participating families and individuals can afford out-of-pocket costs. For example, SCHIP families are not permitted to incur cost-sharing that exceeds 5 percent of family income.
- Public coverage would provide comprehensive benefits that would meet the needs of older and sicker families and individuals. Both programs establish federal benefits standards that are intended to provide comprehensive health insurance coverage. Under Medicaid, states must provide certain minimum benefits such as hospital and physician coverage. Under SCHIP, separate state programs must generally provide a benefits package that is equivalent to several benchmarks including the Blue Cross-Blue Shield Standard Option under the Federal Employees Benefits Health Plan (FEBHP).
- Expanded coverage of parents would also have the added benefit of increasing coverage of children who are currently eligible for, but not enrolled, in the Medicaid and SCHIP programs. Although nearly 95 percent of uninsured children in families with incomes under 200 percent of the federal poverty line are now eligible for Medicaid and SCHIP, substantial numbers of eligible children remain uninsured.[20] Research has found that extending health insurance to low-income parents in the same programs boosts coverage of their children. In states that have expanded publicly funded coverage to include working parents, enrollment rates among children are significantly higher.[21]

Insurance for the Unemployed

The House of Representatives late last year passed an economic stimulus proposal that included a tax credit certain unemployed individuals could use to purchase

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[19] Lisa Dubay, *Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says*, Kaiser Family Foundation (October 1999); Kathleen Call et al., "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," Journal of the American Medical Association (October 8, 1997), p.1191–95; Leighton Ku, Marilyn Ellwood et al., "The Evolution of Medicaid Managed Care Systems and Eligibility Expansions," Health Care Financing Review (Winter 2000); Jeremy Alberga, *Wisconsin's BadgerCare Program Offers Innovative Approach to Family Coverage*, Robert Wood Johnson Foundation (January 2001); Amy Lutzky and Ian Hill, *Has the Jury Reached a Verdict? States' Early Experiences with Crowd-Out Under SCHIP*, Urban Institute (June 2001); Richard Kronick and Todd Gilmer, *Insuring Low-Income Adults: Does Public Coverage Crowd-Out Private?*, Health Affairs (January/February 2002).

[20] Matthew Broaddus and Leighton Ku, *Nearly 95 Percent of Low-Income Uninsured Children Now Are Eligible for Medicaid or SCHIP*, Center on Budget and Policy Priorities (December 2000).

[21] Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*, Center on Budget and Policy Priorities (September 2000); Jeanne Lambrew, *Health Insurance: A Family Affair*, Commonwealth Fund (May 2001); Lisa Dubay and Genevieve Kenney, *Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*; Kaiser Family Foundation (October 2001); Elizabeth Gifford, Robert Weech-Maldonado and Pamela Farley Short, "Encouraging Preventive Health Services for Young Children: The Effect of Expanding Coverage to Parents," Pennsylvania State University, presentation at the Academy for Health Services Research and Health Policy Conference, Atlanta, June 12, 2001.

COBRA coverage *or* health insurance in the individual market. The tax credit would be equal to 60 percent of the cost of health insurance. Only workers currently eligible for unemployment insurance could receive the tax credit. If the tax credit is used in the individual market, the worker must have previously had insurance for 12 months.

Many workers who become unemployed do have difficulty affording the COBRA continuation coverage for which they are eligible. With the costs of a family health insurance policy under COBRA averaging more than $7,000, it is unlikely that many unemployed workers—particularly those with low or moderate incomes—could afford to maintain their insurance. A 60 percent tax credit subsidy, however, still leaves the necessity to pay 40 percent of the COBRA premium. A family getting by on unemployment insurance is quite likely to find an average after-credit premium cost of $2,800 (in addition to deductibles and co-pays) unaffordable. So this proposal is most likely to help families that are unemployed, receive unemployment compensation, but also have sufficient resources from savings or another worker in the family that can be used to pay these health insurance premiums.

The aspect of the plan that would make the tax credit available for the purchase of insurance in the individual market is even more problematic. As noted above, the individual market is largely unregulated and lacks the advantages of group insurance purchased through employers. Many plans sold on the individual market impose high deductibles and offer limited coverage. Furthermore, premiums in the individual market can vary based on risk factors such as age and medical history. The new proposal lacks substantive insurance-market reforms to ensure that individual health insurance policies that provide adequate coverage will be made available at affordable prices to unemployed workers in the individual health insurance market. Under the proposal, states would have to guarantee that some form of individual coverage is made available to laid-off workers who previously had employer-based coverage, but similar requirements are part of current law and most states comply with them simply by allowing individuals who otherwise cannot secure coverage to purchase insurance through high-risk pools. As described above, policies sold through high-risk pools generally are unaffordable and the coverage provided is usually limited; as a result, few individuals purchase insurance through these pools.

Only individuals who are receiving Unemployment Insurance payments would be eligible for the tax credit included in the House stimulus bill. This would leave out a substantial number of low-income unemployed workers, including most part-time workers and more recently employed workers, many of whom have recently left welfare for work.

A better proposal would provide a deeper COBRA subsidy—delivered through a direct payment arrangement with insurers and employers so those without minimal up-front resources could use it—coupled with an option for states to cover under Medicaid (with a 90 percent federal match) those unemployed persons who do not have COBRA coverage or who cannot afford their share of the COBRA premium. This is similar to the proposals included in the Senate Finance Committee stimulus package. This alternative proposal covers a significantly larger proportion of the unemployed, since it is not limited solely to those covered by Unemployment Insurance.

In addition, a COBRA plus Medicaid option assures that most older, sicker unemployed persons can access the comprehensive insurance they need. For example, a 55 year old construction worker who becomes unemployed may have worked for a company too small to be required to offer COBRA. If he has a history of heart problems or any one of a number of other serious conditions, he probably would not be able to access insurance in the individual market. But he could be eligible for comprehensive insurance through the Medicaid program.

The tax credit approach to helping the uninsured has still one more drawback. If the tax credit in the House stimulus bill is enacted, subsequent efforts almost surely will be made to broaden this credit into a general individual health insurance tax credit—of the type included in the Administration's budget—that can be used to purchase insurance in the individual market by employed as well as unemployed individuals. As described at length above, such a general individual health insurance credit could have deleterious effects on insurance coverage.

Conclusion

The tax credit that the Administration proposes poses a threat to the employer-based health insurance system. While this proposal may expand coverage to some currently uninsured Americans, many others who have insurance through their employers may lose their coverage and become uninsured. It is theoretically possible to design a tax credit that does not have as many negative effects, but doing so would require substantial reform of the individual insurance market and some com-

bination of mandates on employers, states, and/or individuals—all of which is not likely to be politically acceptable. A far better alternative to address the problem of the uninsured would be to provide states additional federal SCHIP funds to expand coverage to parents of children eligible for public programs. That has the side benefit of encouraging enrollment of eligible children who are not currently enrolled in those programs.

For the immediate problem of helping the unemployed maintain health insurance coverage, the House-passed proposal for a tax credit for people receiving unemployment insurance would reach only a limited group of the unemployed and, given the problems with the individual insurance market, would fail to provide many older and sicker workers with the insurance they need. A deeper COBRA subsidy delivered directly through insurers and employers coupled with a largely federally-paid option for states to cover unemployed workers under Medicaid could provide better coverage to more unemployed workers.

APPENDIX

Expansion of Medical Savings Accounts

The Administration's fiscal year 2003 budget proposal includes additional tax proposals related to health care, including a proposed expansion of Medical Savings Accounts.[22] In this appendix, I would likely to briefly address concerns with the MSA proposal, which like the tax credit, is likely to weaken the conventional employer-based health system.

Established under a limited demonstration project scheduled to expire at the end of this year, MSAs are tax-advantaged personal savings accounts available to the self-employed and employees at small businesses who are covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of out-of-pocket health care costs. They also may be retained in the MSA accounts and placed in investment vehicles such as stocks and bonds, with the investment earnings accumulating tax-free in the accounts. The funds may be withdrawn for *non*-medical purposes upon retirement. As a result, MSAs can be used as a tax shelter.

Despite the findings of an array of analyses by respected research institutions that widespread use of MSAs could destabilize the health insurance market (findings the demonstration project has failed to dispel), the Administration is proposing a package of MSA changes that have long been pushed by insurance companies that sell MSA policies and conservative policy institutions. The Administration proposes to repeal most current protections and limitations on MSAs, to make MSAs more lucrative as tax shelters for affluent, healthy individuals (and hence more attractive to such individuals), and to allow unlimited expansion of MSAs across the country.[23] The risks of such a course are great.

Adverse Selection and Its Effect on Conventional Health Insurance

Research by the RAND Corporation, the Urban Institute, and the American Academy of Actuaries has found that premiums for conventional insurance could *more than double* if MSA use becomes widespread.[24] This is because of the extensive "adverse selection" in the health insurance market that would likely ensue. If MSAs become broadly available, substantial numbers of healthy, affluent individuals may opt for them in lieu of conventional, employer-based group insurance policies. As a result, those remaining in group insurance would be less healthy, on average, and premiums for conventional group insurance would have to increase.

High deductible policies and MSAs are most attractive to younger, healthy individuals, because such individuals do not expect to incur significant health costs and thus can anticipate accumulating significant amounts in their tax-advantaged MSA accounts. MSAs can be particularly attractive to higher-income individuals, a group

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[22] These proposals are analyzed in the following papers. Edwin Park, *Health Insurance Proposals in Administration's Budget Could Weaken the Employer-Based Health Insurance System*, Center on Budget and Policy Priorities (February 2002); Edwin Park, *Administration's Budget Includes Additional Health Tax Cuts That Primarily Benefit Higher-Income Individuals*, Center on Budget and Policy Priorities (February 2002).

[23] U.S. Department of Treasury, *General Explanations of the Administration's Fiscal Year 2003 Revenue Proposals* (February 4, 2002), p. 26–29.

[24] Emmett B. Keeler, et al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?", Journal of the American Medical Association (June 5, 1996), p.1666–71; Len M. Nichols et al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, Urban Institute (April 1996); and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues* (May 1995).

that also tends to be in better health than people with lesser incomes, since they can benefit handsomely from the tax sheltering advantages of MSAs, which are worth the most to those in higher tax brackets. The attraction of MSAs to healthy, affluent individuals would be significantly enhanced under the Administration's proposal, which would alter the rules governing MSAs in ways that would make the accounts more lucrative as tax shelters. While evidence is very limited, in a preliminary survey of insurers in 1998, the General Accounting Office found evidence that MSAs may indeed be encouraging adverse selection in health insurance markets.[25]

The increase in premium costs that would be expected to result if use of MSAs becomes widespread and significant numbers of healthy individuals withdraw from employer-based plans could lead many employers either to cease offering coverage or to raise the percentage of premium costs that their employees must pay. Such steps would make insurance less affordable and likely cause more people to become uninsured.

Increased Use of MSAs as a Tax Shelter

The Administration's proposal would also make MSAs more attractive as a tax shelter to healthy, affluent individuals by removing or weakening many safeguards Congress enacted to prevent MSAs from turning into a significant tax shelter opportunity.

MSAs are similar to tax-deductible Individual Retirement Accounts in that the deposits an individual makes in these accounts are tax deductible and the earnings that accumulate in the accounts are tax-free. (The funds in the account are never taxed as long as they either remain in the account or are withdrawn for medical purposes; the funds are subject to taxation if withdrawn for non-medical purposes, just as funds in tax-deductible IRAs are subject to taxation when they are withdrawn.) MSAs differ, however, from IRAs in one key respect—there are no income limits on MSAs that prevent wealthy people from making tax-deductible contributions to them. Indeed, the higher an individual's income, the greater the tax benefit an MSA provides. By opening MSAs for widespread use and eviscerating a number of the current limitations and safeguards on MSAs, the Administration's proposal would essentially enable high-income individuals to circumvent the IRA income limits by using MSAs for the same purpose—as tax shelters to accrue substantial assets over time on a tax-advantaged basis. At retirement, funds can be withdrawn from MSAs penalty-free for *non*-medical purposes. In the same GAO survey of insurers, there were indications that MSAs were in fact being marketed primarily as tax-sheltered savings vehicles rather than as sources of tax-sheltered funds for reimbursement of medical expenses. The report stated that insurers were targeting certain segments of the insurance market such as highly-paid professionals, farmers, ranchers, partnership firms and association groups.[26]

Chairman THOMAS. Thank you, Ms. Lav.

Mr. Lemieux?

STATEMENT OF JEFF LEMIEUX, SENIOR ECONOMIST, PROGRESSIVE POLICY INSTITUTE

Mr. LEMIEUX. Thank you, Mr. Chairman.

The Progressive Policy Institute (PPI) has long argued that tax credits should be a cornerstone for a renewed push toward universal health coverage. That is not to say that tax credits alone are enough to do the job. They are not. We will also need expanded safety net programs and greatly improved purchasing pools or other purchasing arrangements, so that people can use their tax credits in an efficient, fair, and secure market, but tax credits are a very important building block.

[25] U.S. General Accounting Office, *Medical Savings Accounts: Results from Surveys of Insurers* (December 1998), GAO/HEHS–99–34.

[26] GAO.

I think that past efforts to get universal coverage have failed mostly because they caused uncertainty about the fate of employer-based coverage, which workers value very highly. However, I think that universal coverage can be achieved in the coming years, in this decade, perhaps, in a series of responsible, practical steps that enhance rather than threaten work-based coverage.

I think the first step, as you have already been working on, is to help the newly unemployed maintain their coverage. By preventing those with insurance from losing it when they lose their jobs, we can at least stop the number of uninsured from rising.

The second step is to actually reduce the number of uninsured by making certain that all Americans have good choices of health insurance at reasonable group rates; that they can exercise those choices in the most convenient and secure setting possible, that is usually their place of employment; and that financial assistance based on tax credits, like we have been discussing today, is provided to help those with low incomes.

And we have heard from virtually every witness, I think, and many Members, that to be effective at reducing the uninsured tax credits have to be both refundable and available in advance, when people need the money to purchase their coverage. Both the House-passed proposal for temporary tax credits for displaced workers and the Administration's proposed permanent tax credits for individual coverage pass those tests of refundability and payment in advance.

The temporary tax payments for displaced workers also seem to me to pass the crucial test of not threatening employer-based coverage. However, I believe the Administration's proposal for permanent tax credits for individual health coverage would in fact still disrupt employer-based coverage, in spite of their new mentions of purchasing groups in this year's version, and therefore shouldn't be enacted in its current form.

I have some suggestions to improve both proposals. They are very technical. They are explained in more detail in my prepared statement.

Some of the highlights: I encourage Committee Members to consider increasing the percentage subsidy for the temporary tax credits for displaced workers from 60 percent to a higher number, say 75 percent or more. I think that would better ensure that very few workers actually lost their health coverage when they were unemployed. And, perhaps surprisingly, I think that could help reduce employers' overall health costs by virtually eliminating adverse selection in the COBRA market.

Furthermore, I think we need to make sure that those temporary tax credits follow people to their new job for a time. Even if you get a new job, you might not be eligible for health insurance for a long period, and those tax credits, if they were to follow people to their new job, that would provide a good incentive to help people go ahead with their job search.

Second, the Administration's proposal for permanent credits for individual health insurance needs to be expanded to include employment-based coverage, and should be made available through payroll deduction at the workplace. And with the balance of my time, let me try and explain that last point, why the Administra-

tion's tax credit should be extended to people with employer-based coverage.

I think the biggest flaw in the Administration's proposal there is that it doesn't allow people who get health coverage at work to receive tax credits even if their incomes are very low. First, that is unfair, since low-income people who already struggle to afford work-based coverage would get nothing. They would have an incentive to drop out of their employer's coverage and switch to other, often higher paying jobs that didn't offer coverage because in general, as we know and as you have said, Mr. Chairman, businesses that don't offer benefits like health insurance can afford to grant higher wages instead.

Under the Administration's proposal, low-income workers would have a particularly strong incentive to take higher wages instead of the employment-based health benefits, and then use the tax credit to purchase individual coverage if they can. To save their employees the hassle of switching into no-benefit jobs to take advantage of the credits, and to retain valued employees in some cases, some small businesses would just stop offering coverage in the first place.

I believe the better path toward universal coverage is to make mainstream group coverage available through tax credits, and easily affordable through tax credits, and easily available at every workplace, whether or not the employer offers to help pay for that coverage. And I am heartened by the fact that even our friends at the Heritage Foundation, which has previously proposed some individualized health insurance reform proposals, they are now publishing papers that go through exactly how we can get tax credits available at the employer level, and I think that is extremely helpful.

To sum up, the PPI strongly supports the effort to make refundable tax credits an integral part of health reform and covering the uninsured. The tax credits shouldn't favor employer coverage or individual coverage. The right policy would be a better balance than the policies the Administration has put forward. Tax credits should be available in both markets so that both markets are strengthened, but one market shouldn't be favored over the other. Thank you.

[The prepared statement of Mr. Lemieux follows:]

Statement of Jeff Lemieux, Senior Economist, Progressive Policy Institute

Thank you, Mr. Chairman, Representative Rangel, and committee members, for inviting me to testify on using tax credits to increase the number of Americans with health insurance. My name is Jeff Lemieux, and I am the senior economist for the Progressive Policy Institute (PPI). Prior to this position I worked for the Bipartisan Medicare Commission, the Congressional Budget Office, the Health Care Financing Administration (HCFA), and an economic forecasting firm then known as DRI/McGraw-Hill.

Universal health coverage is a national imperative. It can be achieved in a series of responsible, practical stages, and the PPI has long argued that tax credits should be a cornerstone of that effort. The first step is to help the newly unemployed maintain their health insurance. By preventing those with insurance from losing it when they lose their jobs, we can at least prevent the number of uninsured from rising.

The second step is to reduce the number of uninsured Americans by making certain that all have good choices of health insurance at reasonable group rates, that they can exercise those choices in the most convenient and secure setting possible

(usually their place of employment), and that financial assistance (based on tax credits) is provided to help those with low incomes.

After a few general comments, my remarks focus on two specific proposals: the temporary tax credits targeted to displaced workers receiving unemployment insurance that the House passed in December as part of the debate on economic "stimulus," and the proposal for permanent means-tested tax credits for individual health insurance that was included in the President's budget.

By tax credits for health insurance, I am referring to tax credits that are both refundable—that is, fully paid even to those whose incomes are so low that no income tax liability is owed—and available "in advance," when the insurance is purchased. Otherwise, low-income workers most at risk of being uninsured would be unable to take advantage of the credits. Both the House-passed proposal for displaced workers and the Administration's tax credits for individual coverage pass those tests.

Two of the greatest strengths of the U.S. economy are our work ethic and the flexibility of our labor markets. Now more than ever, Americans move into and out of the workforce and particular jobs, sometimes working part-time and sometimes overtime, sometimes working for large or small firms or several firms at once. Freelance and independent work is common.

Labor market flexibility is both economically efficient and socially helpful. It allows us to tailor our skills and work styles closely to our social and family needs. However, we need to do much more to adapt benefits like health insurance to the realities of the modern workplace. Specifically, we should strengthen the bond between work and health insurance, and ensure all Americans have a fair chance to obtain good coverage, no matter how or where they work.

The foundation of health coverage in the U.S. is subsidized group health insurance, arranged through employers. Past pushes for universal coverage have failed primarily because of uncertainty about the fate of work-based health coverage, which people value very highly.

The main reasons for the success of employment-based health insurance are the subsidies and the group insurance pools. Subsidies provided by employers make health insurance desirable even for the young and healthy, and group pooling makes coverage fair and affordable, even for those who are older and more likely to need extensive health care services. Getting health coverage through employers is also convenient and reassuring. Employers handle the paperwork and payroll deduction of premiums, and can help resolve disputes with health plans.

The one major problem with employment-based coverage is choice: Too few workers have a wide choice of health plans. Employers may switch health plans abruptly, severing employees' relationships with health providers. And workers routinely have to switch health plans when they change employers.

On the other hand, the market for individual health insurance is small, fragile, and problematic. Although availability varies from state to state, individual coverage can be hard to get or even unaffordable, especially for people with health problems—precisely those who most need health coverage. Fear that only persons with hidden illnesses will apply for coverage causes insurers offering individual coverage to "load" premiums with extra amounts to hedge against unseen risks.

In sum, the market for employment-based coverage is robust, but often lacks choices, which can thwart continuity of health care. The market for individual coverage is weak and unpredictable—in ways that also reduce choice and continuity.

Ideally, public policy should help employers offer a wide menu of health insurance choices. That would allow workers to stick with a plan they like, even if they switch jobs. Since more and more workers are self-employed, we must also improve individual coverage. That market needs the best features of employer coverage: It should be more predictable, affordable, fairly priced, and available to all.

The best policy would be a combination of tax credits and new group purchasing arrangements. That would help inject choice into the market for employer coverage, and would bring choice, subsidies, and group coverage to people who can't get work-based coverage.

Ideally, tax credits shouldn't favor employer or individual health coverage. The current tax law favors employment-based coverage, but the Administration's proposal of permanent tax credits only for individual coverage is an overreaction, favoring individual coverage, especially for lower-income workers. The right policy is a balance. Tax credits should be available in both markets, so that both markets are strengthened.

Temporary Tax Credits for Transitional Health Coverage

The House-passed bill would give a 60 percent, uncapped tax credit for either COBRA continuing health coverage or individual coverage. In general, displaced workers receiving unemployment benefits would be eligible for up to 12 months.

The PPI has argued that tax credits for COBRA coverage would be beneficial not only to displaced workers, but also to employers. Under COBRA, most workers who are laid off are allowed to remain in their employer-based health plan for up to 18 months, provided they pay the full premium (their share plus the employer share) and a small administrative fee. The problem is, the full premium for employment-based coverage averages about $200 per month for self-only coverage or around $600 per month for family coverage.

Since COBRA coverage is very expensive, many laid-off workers choose to remain uninsured, gambling that they won't get sick before they find another job. However, workers who already have a chronic health condition generally accept COBRA coverage, despite the high cost. Otherwise they would have no protection against high medical bills they know they will face.

In the jargon of health insurance, employers offering COBRA coverage experience "adverse selection," that is, healthier-than-average ex-workers decline the continuing coverage, and sicker-than-average workers accept. Even though the workers who accept coverage pay the full premium, their costs are actually higher than average, which drives up the premium for the employer's whole group. Although only a small fraction of ex-employees accept the coverage—approximately 25 percent—it still drives up employers' health costs.

Based on past estimates from the Congressional Budget Office, over half of laid-off workers would accept COBRA coverage with a 60 percent subsidy. In my opinion, that would certainly reduce adverse selection by drawing younger and healthier workers into COBRA pools. It could even reduce employers' overall costs because the reduction in costs associated with adverse selection could be enough to offset the additional cost of increased participation.

However, there is one way to be sure: raise the subsidy rate from 60 percent to 75 percent or more. As the subsidy increases, it is reasonable to assume that each subsequent person enticed to purchase coverage is a little healthier than those who would have purchased at a lower subsidy. At a 75 percent subsidy, most unemployed workers could afford to stay on COBRA, adverse selection would probably be very small, and employers' overall costs would be more likely to decline.

The House-passed proposal also allows the tax credits to be used for individual coverage. That is important, because firms with fewer than 20 employees are not required to offer COBRA coverage, and workers laid-off from those firms would not be able to continue their employer-based coverage in any event. The bill also allows workers eligible for COBRA to use the tax credit for individual coverage instead.

Allowing workers eligible for COBRA to use the credit for individual coverage doesn't change the relative price of health insurance they face. Previously, a laid-off worker could choose COBRA or individual coverage with no subsidy. With a percentage subsidy of any amount, the relative price doesn't change. Economists would say that the substitution effect in that case is zero—because the price of COBRA didn't change with respect to the price of individual insurance, there is no reason for people to change their decision between the two.

However, there also could be a so-called income effect. That is, the presence of a subsidy gives the worker a higher net income after purchasing health insurance—that effect can also impact purchasing decisions. In this case, I think it is reasonable to assume laid-off workers would be very concerned about holding on to their familiar employer-based health coverage. Although any income effect in this case would probably be faint, I believe it would work in the direction of people choosing COBRA coverage.

In sum, under current law a laid-off worker eligible for COBRA faces a choice of COBRA or individual coverage with no subsidy. Most go uninsured. With a subsidy of 75 percent or more, most would choose insurance. Those who would have purchased COBRA without any subsidy would almost certainly choose COBRA over individual coverage if equal percentage subsidies were offered. Those who would have purchased individual coverage would probably stick with that too, although some may switch to COBRA if subsidies were offered.

We don't know whether COBRA-eligible workers who otherwise would have been uninsured would choose COBRA or individual coverage after a tax credit was offered. Some would probably choose individual coverage. Therefore, the improvement in adverse selection in the COBRA market would not be as great if subsidies were also available for individual coverage—as in the House-passed bill—compared with proposals that would restrict the subsidy to COBRA coverage alone.

Permanent Tax Credits for Individual Coverage

The Administration proposes to give low-income people who can't get health coverage at work a refundable tax credit of up to 90 percent of their premium up to limits of $1,000 per covered adult and $500 per child, up to two children. Therefore, the maximum credit would be $3,000 for a two-adult, two-child family. The proposal would allow the tax credits to be used for individual coverage, or coverage obtained through a purchasing group or high-risk pool.

These tax credits would be available in full for single people with annual earnings of $15,000 or less, or families with earnings of $25,000 or less. The credits would phase down to zero for individuals with annual incomes of $30,000, one-adult families with incomes of $40,000, or two-adult families with incomes of $60,000 a year.

The proposal would use a novel procedure to make the credits available in advance: People would prove their eligibility based on their previous year's tax data. Individuals would present their earlier tax forms to an insurance company or purchasing group to demonstrate eligibility; then the credit would be deducted from their premium. That is an unwieldy procedure—it requires insurance companies or purchasing groups to adjudicate eligibility based on personal tax returns. However, workers would not be obliged to "reconcile" the tax credits they received in that manner on their end-of-year tax forms in order to calculate their tax credits with greater precision and up-to-date income data.

The biggest flaw in the Administration's proposal is that it does not allow people who could get health coverage at work to receive tax credits, even if their incomes are very low. That is unfair, since low-income people who can't afford coverage at work (or who struggle to afford work-based coverage) would get nothing. They would have an incentive to switch to other (often higher paying) jobs that don't offer coverage.

In general, businesses that don't offer employee benefits like health insurance can afford to grant higher wages instead. When they decide to hire or retain a worker, businesses focus on the cost of the total compensation package, not the split between cash wages and non-wage benefits. Of course, individual workers may not always be able to trade benefits for wages, because they may not have a wide choice of jobs with different mixes of compensation available to them at any one time. But in the overall economy and over a sufficient period of time, the choice of health benefits versus higher wages is very real.

Under the Administration's proposal, low-income workers would have a particularly strong incentive to take higher wages instead of employment-based health benefits, and then use the tax credit to purchase individual coverage. To save their employees the hassle of switching into no-benefit jobs to take advantage of that incentive (and to retain valued employees), some small businesses would just stop offering coverage in the first place. That would reverse the recent trend toward more small employers offering coverage to their employees.

Second, because its tax credits would cover up to 90 percent of a premium, the Administration's proposal could spawn the development of inferior insurance plans for low-income people. For example, the Administration's plan would give an individual purchasing a $1,000 policy a tax credit of $900 (90 percent of $1,000). Similarly, someone purchasing a really cheap $500 policy would get a tax credit of $450 (90 percent of $500). The Administration's tax credit would pay 90 percent for premiums costing up to roughly $1,110 (the maximum $1,000 credit is approximately 90 percent of $1,110). The problem is: any coverage valued at $1,110 or less is probably pretty meager coverage. (For example, the average premium for self-only coverage purchased through employers is about $2,400.) Low-rate insurance would be better than nothing, but it might not really solve the core problem: getting everyone access to high-quality medical care.

One simple way to improve the Administration's proposal may seem counterintuitive: reduce the maximum percentage of a health insurance premium the tax credit could cover from 90 percent to 50 percent across the board. That would give people incentives to purchase full coverage—for example, a person wishing to obtain the full $1,000 credit would have to purchase health insurance worth $2,000, which is closer to the value of mainstream coverage. Those wishing to purchase cheaper, less generous coverage could still do so, but they wouldn't get the maximum $1,000 credit, and the credit couldn't cover more than half of the premium in any case. Because young and healthy workers could not get the full credit for cheap, barebones coverage outside the workplace, they would have a stronger incentive to stick with employer-based coverage (and their employers would have a much weaker incentive to drop coverage on their behalf).

On the downside, fixing the Administration's tax credit so that it could cover at most 50 percent of the premium would reduce the number of very young or healthy people who would be induced to purchase insurance. It would give them an incen-

tive to purchase more expensive coverage with a richer set of benefits than might otherwise be available.

However, we should not try to get health insurance to young, healthy people by discouraging employer-based coverage or encouraging low-rate benefits. The better path toward universal coverage is to make mainstream group coverage affordable and easily available at every workplace (whether or not the employer helps pay for coverage) and in every state.

Therefore, a second way to improve the Administration's proposal would be to allow low-income workers to use the credits toward the purchase of employer-based coverage. Since employer-paid health premiums are already excluded from employees' incomes, the caps on tax credits for employer-subsidized coverage should be lower than those for individual coverage. That would keep the tax treatment of employer coverage and individual coverage roughly equal, and thereby eliminate incentives tilted toward one form of coverage.

Finally, the tax credits should be administered—at least as an option—through the workplace. All employees, on their first day on the job and each year thereafter, should receive an enrollment form for health insurance. At the very least, that enrollment form should contain a menu of options. States should take on the role of ensuring that options for reasonably priced group coverage were available, ideally through purchasing groups. A special version of the Federal Employees Health Benefits program could be used as a backup, if states didn't ensure a choice of coverage was available.

Employers who sponsor coverage would deduct premiums from employees' paychecks, as they do now. In addition, they would add back to an employee's pay the tax credit for which the employee was eligible, up to the amount of the employee's share of the premium. In effect, companies would give tax credits to their employees as they purchased coverage, right on their paychecks. The government would pay employers back contemporaneously, through bookkeeping adjustments in the amounts withheld and sent to the federal government for employees' tax payments.

Employers who do not sponsor coverage would nevertheless give their employees enrollment forms for at least one menu of health plans. (Those employers could provide options from other insurance companies or groups, but at the very least would supply a form for a menu of health plans put together by the state.) Like firms that sponsor coverage, they would handle payroll deduction of premiums, forwarding those payments to the purchasing group. They would also add back to employees' paychecks the tax credits for which the employees were eligible. Again, the company would be reimbursed for the tax credits via its business tax arrangements.

How would employers know whether or not an employee was eligible for a tax credit? The employee's hourly wage could be used as a guideline. A schedule of hourly wages could be drawn up to match the Administration's annual earnings limits.

Tax credits provided on employees' paychecks should probably also be reconciled on their end-of-year tax returns. At the end of the year, the company would show the amount added to workers' pay from the tax credit on their W–2 forms. Then workers would file for the tax credit on their tax returns; that would be the final determination of exactly how much they would receive. The IRS could add a worksheet on the W–4 form so that employees with multiple jobs or a spouse who works could figure an appropriate amount to add to their pay.

Reconciling tax credits advanced through the workplace or health insurers could reduce the number of people willing to take them in the first place, if they feared having to pay the money back at the end of the year. But it would also allow workers whose employers paid 100 percent of the premium for health insurance (and received less in wages as a result) to share in the credit. That is the only truly fair way to distribute tax credits, and it would ensure there were no incentives for employers to reduce the share of health premiums they pay.

Conclusion

While the latest economic indicators signal improvement, I believe for several reasons that the economic recovery is likely to be weak, and unemployment will keep rising for some time. Meanwhile, after a long period of slow growth, health insurance premiums are increasing rapidly. The combination of a slow economic growth and rising health premiums will cause the number of the uninsured to rise, perhaps significantly.

The PPI strongly supports the effort to make refundable tax credits an integral part of a renewed drive toward universal health coverage. I encourage committee members to increase the subsidy level of the temporary tax credit for displaced workers from 60 percent to 75 percent or more, to better ensure that few workers would lose health coverage and that employers' health costs would be reduced. The Administration's proposal for permanent credits for individual health insurance

should be expanded to include employment-based coverage, and should also be made available through payroll deduction at the workplace. In any event, the percentage of the premium for those tax credits should be reduced from a high of 90 percent to a flat 50 percent to encourage comprehensive coverage.

Chairman THOMAS. Thank you very much. So what I am hearing, Mr. Lemieux, is that the mechanism is okay, it is just the mechanics surrounding it, the way in which it is utilized. But the tax credit itself, if it is done correctly, is a model that your group would support.

Mr. LEMIEUX. Yes, sir. Tax credits should be a cornerstone for the drive toward covering the uninsured.

Chairman THOMAS. Thank you.

Ms. Lav, in describing the potential horrors of this system, I am not quite clear, do you believe that the Federal law would preempt State law that is now in place?

Ms. LAV. No, I don't think we would go in that direction at all.

Chairman THOMAS. Okay.

Ms. LAV. I mean, I think that that is one of the problems, you know, that you cannot. It is very difficult to fix this individual insurance market, and that is the reason you can't rely on it. I was saying we certainly are not going to mandate States to do this.

Chairman THOMAS. All right. Then do you know that the provision that we proposed has guaranteed issue in it?

Ms. LAV. Well, you know, guarantee issue is, you know, as under HIPAA is one thing, but it is guarantee issue at what price? And when we are talking about credits for low- and moderate-income people, you know, if somebody is willing to issue them a policy at an exorbitant price, it is not any real benefit or choice for them at all.

Chairman THOMAS. And do you understand that the legislation was not a fixed dollar amount, but rather a percentage of the cost of the premium with no cap on it?

Ms. LAV. You are talking about the displaced worker?

Chairman THOMAS. Yes.

Ms. LAV. Yes.

Chairman THOMAS. So that that argument I believe is much less significant if you are provided with a percentage of the cost with no cap.

Ms. LAV. Well, I think if you are living on unemployment insurance, you are going to have trouble paying the other 40 percent——

Chairman THOMAS. No, no. No, I understand all that, but the way you presented it, it was as though if people didn't realize what was in the legislation and it was a fixed dollar amount.

The other thing that I find interesting is the current State laws in all 50 States have guaranteed renewal provisions. And if I were to take the time and go through and look at what States currently provide, all 50 States, for example, require approval of product design, consumer protections, premiums, the provisions which encourage pooling. I just have a very difficult time, for someone who in criticizing it could certainly criticize it because it doesn't do enough, but that what you have done is created some arguments

which I don't believe are valid, and that you immediately then shift to doing more of the same.

Do you agree with Professor Gruber that if you were to enhance Medicaid as you indicated, that it would in fact also undermine the employer-based system?

Ms. LAV. I believe that Professor Gruber has been misquoted here this morning. I am sorry he was not at this hearing to speak for himself, since his name has been invoked so much.

But as I understand it, his data suggest that there is no more than 20 percent displacement from Medicaid expansions, and that the larger data, what has been cited is from a study that was counting people who actually—as being part of the displacement who actually were not eligible for Medicaid, parents of the children. So I think that data that has been quoted here is not——

Chairman THOMAS. Do you believe it is realistic to assume that most States in their current fiscal condition would raise the percent of poverty to cover many of these displaced workers who, as we have discussed, are not really low-income people? Is that a realistic possibility?

Ms. LAV. Well, you know, the Senate Finance Committee proposal was talking about a 90 percent match and, I mean, some people were even talking about a 100 percent match. I think the real issue is how do you get some insurance to these people that is insurance that they actually can use, that is not going to cost them an amount that people cannot afford when they are on unemployment insurance, and that will be available to them even if they happen to have diabetes or some other problem which hasn't prevented them from working, but will prevent them from getting insurance. And so I think there has to be a very, very generous or even a full Federal contribution, but I think the mechanism is a much better one than throwing people onto the individual market.

Chairman THOMAS. And if you provided a 100 percent—I find it ironic that you would use "match" in reference to 100 percent—if you gave the insurance away, would that not have an impact on the employer-based system?

Ms. LAV. For unemployed people? No. I mean, you know, if you are talking about people who are unemployed. It would certainly if you were doing it on the, for the——

Chairman THOMAS. Uninsured.

Ms. LAV. Regular credit, but if you are doing it for the displaced worker—and you would have to have, you know, an income cap. You couldn't let States decide to do it up to 450 percent of poverty. You would have to do it, you would have to place a cap on it, but that certainly is possible.

Chairman THOMAS. Indeed, there would be a number of mandates.

Ms. LAV. But I think 90 percent is what the Center was advocating.

Chairman THOMAS. There would be a number of mandates that you would have to place on States to make it work.

Dr. Butler, thank you very much. I do believe that the Progressive Institute has also matured in its thinking, in terms of the way——

Dr. BUTLER. I am glad to see they have come along so well.

Chairman THOMAS. Yes. But it is a pleasure to have both of you with us.

In terms of the eHealth, Mr. Patel, if we are talking about a credit which is now going to be built into the system, how difficult would it be to modify the software so that people could see what their actual out-of-pocket cost would be, if in fact that were available?

Mr. PATEL. That is a fairly straightforward exercise. It is an additional column that would, under individual single policies, show a minus $1,000. And if they were able and willing to put in their income bracket, then we could show how that scales based on that. But the computational logic in the display is pretty straightforward.

Chairman THOMAS. And is someone able to kind of reverse engineer a plan? That is, if I were looking for one that did prescription drugs in some way but didn't cost more than X dollars a month, can you input parameters for a plan and then see if any match it?

Mr. PATEL. We made it simple for people to put in parameters such as deductibles, co-pays, and they can sort on deductibles, premiums, and other items. When it comes to line item benefits, and that is where our apples-to-apples comparison chart may get pretty straightforward, but not as simple as simply typing in the word "maternity."

Chairman THOMAS. Thank you. Also, I note that there are some folks, perhaps even some on this panel, who are not as computer literate as either they would like to be, or perhaps many people out there. The argument is that this is still very, very exotic stuff, and we are dealing with a limited number of people. One of the terms of the art are a number of hits on a particular site. I mean, obviously if 2,000 or 3,000 people a month access this, it is a pretty limited universe. What are we looking at in terms of the number of hits on eHealth?

Mr. PATEL. If you don't mind me modifying the question, "hits" sometimes are misconstrued because the numbers become inflated. Unique visitors to our site are approximately half a million per month.

Chairman THOMAS. Well, that is significantly different because unique visitors could in fact visit the site several times, making different comparisons, and under the normal "hit" terminology each of those would be counted as a hit. You are talking about unduplicated counts. Is that another way of saying it?

Mr. PATEL. We have a mechanism to screen out duplicated visits from the same computer. Hence, these are truly unique visits from unique computers. Hits sometimes include different graphics and different pages——

Chairman THOMAS. Yes. Absolutely.

Mr. PATEL. And again, it is just misconstrued.

Chairman THOMAS. So you are talking, if we could say this in a rough way, and perhaps it is too distorted, but I mean half a million head of households kind of thing looking at it, which then when you add up the number of people that could be impacted by this, gets into possibly the millions fairly quickly, and this is some-

thing that I think will only grow exponentially. So I do want to thank you for your presentations, all of you.

The gentleman from California wish to inquire?

Mr. STARK. I would be glad to yield to Mr. McDermott.

Chairman THOMAS. The gentleman from Washington is elevated to the top of the list.

Mr. MCDERMOTT. I was certainly counting on Mr. Stark to lead this off.

Chairman THOMAS. Does the gentleman wish to defer to someone on this side?

Mr. MCDERMOTT. No, I have a couple questions.

Chairman THOMAS. Okay.

Mr. MCDERMOTT. As you might guess. On the eHealth stuff, I thought the last witnesses were a little bit—well, I don't know—I felt misled a bit, in their talking about these health care plans for which you would pay. And they said, well, the definition is in the bill we passed last year, so I went and got it. And it says, "Qualified health insurance means insurance which constitutes medical care." Now, I don't think you would call that a defined benefit program. That is about as wide-open a definition, as unmeaningful a definition of health care, as I can imagine your paying for.

So when I looked at the eHealth, I looked at the Blue Cross of California for $127, and I suspect, and I don't know enough, I need some help, that you line up these $127 policies for young people. I mean, those would be people who say, "I haven't got enough money for health insurance, so here is a change, and I'm going to go get this." But I notice one thing about it is that it doesn't have any maternity benefits, just exactly what you would expect young people to probably need at some point.

And then you get over into things like pharmaceutical benefits, and you are talking about formularies and a whole bunch of things here. Most people don't—I mean, and that is for $470 a month. I keep thinking about my laid-off Boeing worker—and the Chair is gone. The Chair says you are going to get 60 percent. Now, do I understand that means if it is a $7,000 policy, you get 60 percent of that? You get $4,200? And that somebody in another company that is getting a $3,000 policy, they get $1,800? Is that it? So we are going to have all kinds of levels of benefits, depending on how well people guess about what their health is going to be. Am I seeing how you are constructing this? It is a guaranteed payment, not a guaranteed benefit package, is what I am getting at.

Mr. PATEL. Mr. McDermott, if I can address the pieces that I understand, specifically about the quotation, we put in two 40-year-old adults as well as a child, and so the prices you are seeing reflected in this chart are about 40 year olds. And they have a choice. It is a 40-year-old male—actually it is a 42-year-old male, a 41-year-old female, and a child that is 5 years old. Here what we are demonstrating is that there are options——

Mr. MCDERMOTT. Are they assumed to be absolutely healthy? No medical underwriting in this at all?

Mr. PATEL. Yes. At that point the quotation is typically on what is called Tier 1 pricing data, so it is unadjusted average prices that the health plans actually sell. But I should point out that some of

the plans don't include maternity. The first one doesn't, the much lower priced one at $127 per month for all three individuals, but the $457 policy as well as the $470 policy do include maternity benefits. They are much more robust policies.

And what I am pleased to report to you today actually is, you know, we have an affiliate relationship with the union organization that serves those specific Boeing employees that you mentioned, the SCPEA union, southern California Professional Engineering Association, and off of their own web site they have a pointer to eHealthInsurance, understanding that sometimes COBRA policies can be very expensive, and they would like their people to be empowered to go and shop and find a policy that is right for them. And so I am happy that we are able to serve some of those constituents in the Boeing area.

Mr. MCDERMOTT. But you do recognize that they are going to have less benefits when they come to your—when they leave that Boeing contract and come down onto your Web site, they are looking at less benefits.

Mr. PATEL. I haven't done the comparison.

Mr. MCDERMOTT. But it wouldn't surprise you.

Mr. PATEL. It wouldn't surprise me if there is a difference. But this is a fairly robust policy, when we look at the $450 per month for three people. It includes most aspects of a plan that——

Mr. MCDERMOTT. One week of your unemployment would pay for it, but of course you are going to get this six times, 60 percent of $7,000. You get $4,200 from the government, so you have only got to make up $3,000, huh? If you can do that.

Mr. PATEL. Yes, for the COBRA policy. That is challenging. For a policy that someone might buy on their own, I think this would equate to——

Mr. MCDERMOTT. So you are really suggesting it would be better to leave the Boeing COBRA policy and go down and get one of these individual policies.

Mr. PATEL. It would be cheaper for some people to do that. For those that have health conditions, and where the policies might be more expensive, it is better for them to stay with the COBRA.

Mr. MCDERMOTT. Thank you.

Mr. MCCRERY. [Presiding.] Mr. Houghton?

Mr. HOUGHTON. Thank you very much.

I am sorry I wasn't here for your testimony, Mr. Patel, but you know one of the criticisms of allowing people to purchase individual policies outside the employer structure is that there aren't good policies available on the market, and yet I think you had mentioned something like 87 percent of the policies that you served were sort of comprehensive. I mean, is this sort of representative of the general outside market, or it is just something that you are involved with?

Mr. PATEL. No, I believe what we are demonstrating here is statistically significant and representative of the majority of the United States. You know, on our site we have 10,000 different plans across 100 different health insurance companies, and so the information that we release, when we actually look at the data, we wanted to know, are these bare-bones policies or are they of real substance?

And that is where we found that, you know, two-thirds of the policies had less than a $1,000 deductible and that 87 percent of them are what we considered comprehensive. And that is a very vague term, but it is where we used kind of the equivalent of what is in Medicare A, Medicare B, and some med supplement with prescription drugs to constitute what is comprehensive, and we found that 87 percent of these policies were in fact meeting the definition.

Mr. HOUGHTON. Good. Well, that is helpful. Thank you very much.

Mr. MCCRERY. Mrs. Thurman?

Mrs. THURMAN. Hello, and thank you for being here today and giving us an opportunity to kind of discuss the issues versus just—you know, so we can see where some of the problems are and where potentially we could actually do things to help.

Mr. Patel, I am very familiar with your information and have worked with you, and anything that can give somebody an opportunity to look and be able to see what might be available to them I think is a good idea. You mentioned, though, in your model that you had a 41-year-old, a 42-year-old, and a child. What was the average income? Was there an income in that?

Mr. PATEL. No, we don't have income data. When we ask people to apply for health insurance, they don't share that information.

Mrs. THURMAN. So part of the problem that we have might even be as to understanding, with the tax credits that were being talked about, there may be several of these people that would never be able to, really be able to use that because of the income level that they are at. I mean, we may find that, which I think is quite frankly one of the issues we even have with the uninsured issue of unemployed, because it is based on last year's salary, not this year's, and you have a Boeing employee that was at $30,000 who would not have an opportunity to participate, in my estimation, with any of this.

Mr. PATEL. I could say absolutely yes. I wanted to be very clear that this is not the solution for everyone, and that impoverished individuals will absolutely need a specific solution. And this would represent people in my own family, it would represent people that I have worked with as a Big Brother, that they will need certain programs to help them overcome the affordability barrier. They have not a single dollar of discretionary income to provide toward health insurance. And I have been shocked to find that in some places people below 100 percent of the Federal poverty level even don't qualify for Medicaid.

Mrs. THURMAN. The other question that I have, and maybe this is to Dr. Butler, you know, as I talked about earlier, certainly the issue that is going on in Florida, we have not taken a new high-risk person in since like 1991, somewhere around there. They have got a $100 million deficit. But one of the other things that we are hearing is there is very limited, if any, ability to go out on an outside market as an individual. Maybe in what Mr. Patel is looking at, which is a PPO, is an HMO, managed care, but there are several areas of this country, as we know, that don't have even those instruments available to them.

What kind of research have you done in looking at this tax credit that shows that even if you had a tax credit, that you would have an insurance instrument available to you as an individual?

Dr. BUTLER. I think there are two ways of responding to that. The first is just to amplify what Mr. Patel said, that one of the advantages of a credit that is available for people to go outside say COBRA coverage or any other insurance is that they then can look and they can seek the kind of coverage that is available, that fits their needs.

The second point is that once you provide a subsidy in some way, the market will change, just as the market changed for employer-based coverage once the IRS ruled that you could get a tax exclusion for it. In other words, once you start to put money in people's pockets, then other kinds of markets begin to develop. I am not suggesting that we take a laissez faire approach. I have suggested in my testimony that——

Mrs. THURMAN. Can I ask something in there?

Dr. BUTLER. Yes.

Mrs. THURMAN. In the self-employed, is there a cap on their tax credit? Could they only make up to a certain amount? I don't know the answer to that.

Dr. BUTLER. You mean under current law?

Mrs. THURMAN. Yes, under current law. If they made $80,000 a year, can they still get the——

Dr. BUTLER. I believe it is a straight deduction. Yes, it is a deduction, I believe, without any limit. A credit is much more advantageous for people at the lower income level.

Mrs. THURMAN. And then maybe you two all can give me some ideas of what you are finding out there on the open market for individual instruments of insurance.

Ms. LAV. I mean, unlike the eHealth or the CEA, there was a Kaiser study which looked at people that had—and went beyond the surface to the individual underwriting with people that actually had real life problems, which as I said, half of the uninsured and two-thirds of the low-income older uninsured have. And they found lots of refusals, lots of exclusions, downright refusals, lots of exclusions of whatever that person's problem was, which may be why they need the insurance, and insurance premiums that were two or even three times the basic premium that we are talking about here today. So I think that is really what you would find in the real world.

Mr. MCCRERY. I am sorry. I am going to try to get Rob Portman in before we go vote, and then Pete Stark.

Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman, and thank you for your testimony today and your patience in waiting for us. I guess I have a couple more elementary questions. First, Mr. Patel, I would appreciate your talking a little bit about some of the current opportunities out there, and maybe the additional opportunities that would come with a more vigorous individual market.

And I think Dr. Butler is right, I think the market will change. How much it changes is uncertain in health care. We have seen that, and that is one reason we have a problem today, is that the market hasn't adjusted as some of us thought it might, even in the

current configuration, particularly for smaller businesses. And, you know, I have constituents back home who are coming to me now and telling me woes that sound a lot like 1992, 1993 and 1994. You know, in my own town of Cincinnati we have had a pretty aggressive HMO health care market, and now we are seeing 11, 12, 15, 20 percent increases for smaller businesses.

The first question I would have is really for anybody, but Dr. Butler may be the most qualified to answer it, and that would be, what are other countries doing in terms of the individual market? Most countries have more of a socialized or nationalized system, I suppose, that are developed countries. But do you have any comparative information on this development of an individual market that might be successful?

Dr. BUTLER. Well, I don't have it off the top of my head. In the British market about 10 percent of people are involved in the individual market, or small groups, based on the place of employment. In Switzerland there is in fact an interesting combination of a national program and national subsidy and a requirement for insurance, with private plans being made available to people.

Mr. PORTMAN. Is it like the British system, where you opt out of the national plan, or is it something you do concurrent——

Dr. BUTLER. Unfortunately, in the British system you don't opt out in the sense of getting your money back. You have to buy twice.

Mr. PORTMAN. Right.

Dr. BUTLER. But some people, many people choose to do that because of the deficiencies of the government-sponsored system in Britain.

Mr. PORTMAN. I guess the question I would have is, is there any experience in any other country that we have where we have gone to an individual market and we have been able to see the kinds of affordable health care for individuals that we all like to see in this country? I know you have some ideas about pooling, and particularly among small business——

Dr. BUTLER. Well, I would look at the—I think a good equivalent of what you are talking about is the very health plan that you are in, the Federal employees system, which although it is technically an employer-based system, it is in fact 10 million people shopping as individuals for plans. That is what it actually is.

Mr. PORTMAN. Right.

Dr. BUTLER. And we see a very rich market there and a very effective market.

Mr. PORTMAN. But that market, that depends on a very healthy subsidy as well.

Dr. BUTLER. I don't disagree with that, but all I am trying to point out is that there is a very strong market there for what is a subsidized individual system, and that if you were to provide a subsidy certainly at the 75 percent level, which is what we are talking about in the FEHBP, I think you would solve almost all the problem. If you are not going to get that far, you are obviously not going to solve as much of the problem.

I am just making the point that a market has developed, a very effective market, in the FEHBP system, based on subsidizing people directly and having advanceability, because you get a lower premium and the plan itself gets a direct payment, which is exactly

what the Administration is arguing for. So I think you actually have in place, right before you, the basic structure of a market that would develop if you did provide this subsidy.

Mr. PORTMAN. There was discussion earlier about the efficiencies in various plans, and I think it was Ms. Lav who talked about some of the inefficiencies in an individual market, and yet there are a lot of inefficiencies in the current system. And when you think about it, the way in which we subsidize now through the employer-based system, there are obviously some plans that get a larger Federal subsidy than others based on the kind of plan that is offered.

And the question is, on the individual market, can you overcome some of those inefficiencies by providing more of a blanket subsidy, in essence, or caps on the kinds of plans that are being offered, so you don't have a Cadillac plan and a Ford plan and then some with no plan at all, all of which are subsidized by the Federal government. Do you have a response to that?

Ms. LAV. Well, while there are inefficiencies in almost all of these systems, I think what you are doing is making it worse with the individual market, because in the employer plan, in the FEHBP, you are not saying some people can get insurance if you are healthy and some people, if they are not healthy and you really need it, don't get insurance. And so I think that is the ultimate in efficiency, which is what is throwing people on the individual——

Mr. PORTMAN. But we have built safeguards into the system already, and we could always do more, correct?

Ms. LAV. I am sorry?

Mr. PORTMAN. We have already built in safeguards with regard to preexisting conditions and other prohibitions on exclusions. Couldn't you build that into a system?

Ms. LAV. Not unless you are willing to go to some kind of community rating or price control so people could actually afford it if they are sick, because insurers always will have the advantage, if they can, to shed the individuals who they think are going to cost them money. And they won't want to take them up, and unless they have to take them up, just as in the FEHBP the insurers have to take all comers, then it is not going to work.

Mr. PORTMAN. Right. Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Stark?

Mr. STARK. I guess I will just have to ask you to raise your hands, but I am going to guess that we could provide Medicare for the under-65 population for probably $3,000 a year. It was $4,000 for the 55 to 65, for the buy-in, so I am extrapolating. Kids are only about $1,000, so you can fuss with me about the $3,000, but I am pretty close.

If you add a maximum co-pay of $1,000, one exposure to the hospital, and $100 for the doctor, you are talking about at most $4,000 for a plan that—I handed out this list of benefits that I got off the e-group—that is probably just as good as that, and most of those had a $3,000 premium and a $1,000 co-pay. So you could have Medicare with completely open enrollment and community rating, and why would anyone therefore object if using this tax credit, we allowed people to purchase Medicare as an alternative?

That is all we would need to keep the insurance companies honest. If they want to compete, let them compete. And we already have it for the seniors, where obviously the private insurance didn't want to compete. And so I would be perfectly willing to say, "Okay, let's do it," but just let Medicare offer a plan at budget net and cost as we do now, with the subsidy for part B no higher, and go at it that way. Who would object to that?

Dr. BUTLER. I think you would immediately see, of course, the adverse selection against Medicare, which is one of the big concerns with that. The people who would quickly and immediately take that option would be the people with the highest cost.

Mr. STARK. Yes, but our first concern is the guy who doesn't get any insurance through the highest market.

Dr. BUTLER. I understand that. I am just trying to point out that the cost of providing that coverage——

Mr. STARK. It is interesting to see how the conservatives always worry about the poor people and the sick people first, that they are jamming it to us rich healthy people. I like that, Stuart. You are true to form. Always worry about the rich people, never give a hoot for the poor. At least you are consistent.

Dr. BUTLER. Well, I think my record is very clear on that, Congressman.

Mr. STARK. Yes, your record is very clear. You don't give a rat's behind for the poor and the indigent. All you worry about is rich people getting their tax breaks.

Dr. BUTLER. Congressman, I——

Mr. STARK. Your career is outstanding in that regard.

Dr. BUTLER. If you look at the proposals that I have actually put forward, you will find that in fact I, like Mr. McDermott and Mr. McCrery have been more radical than most in terms of saying we should in fact remove the subsidy almost entirely from the rich people who get the current exclusion, and provide it almost entirely to middle—and low-income people, and I am on the record as saying that.

Mr. STARK. Well, all I have to say to you is, "Bunk."

Mr. MCCRERY. I have a related question to Ms. Lav, kind of the flip side of this. Ms. Lav, I appreciate your objections of a subsidy or a tax credit with respect to very low-income people, that a tax credit is not going to do them any good if they have to come with $1,000 or $2,000 out-of-pocket to make it, to pay the full premium. My question to you, though, is would you be willing to cap the current tax subsidy for employer-provided health insurance in order to finance more generous tax credits for low-income people?

Ms. LAV. I don't think that particular tradeoff would be a very good one, because——

Mr. MCCRERY. Why not?

Ms. LAV. Even though I am saying that the tax credit is inadequate, my written testimony reflects this, I am not really willing to say that there should be a bigger tax credit, because the larger the tax credit, the more you are pulling away from the employer-provided system. I actually would like to see——

Mr. MCCRERY. Okay. Well, let's say we are going to expand Medicaid. Let's say we are going to expand Medicaid. That costs money, too. How about capping the tax subsidy on employer-pro-

vided health insurance to pay for the increase in the Medicaid program? Would you be in favor of that?

Ms. LAV. I actually have not analyzed that trade-off, so I am not really prepared to——

Mr. MCCRERY. So you are saying you could maybe live with a cap on the tax subsidy for health insurance?

Ms. LAV. I am not saying that. I am saying that, you know, I think we do not want to ruin the part of the health insurance system that works well, and I think that is the employer-provided system. So I think we would have to go very, very cautiously there. We don't want incentives for employers not to provide insurance, and they already are having incentives not to. You know, we already have very rapidly rising health care costs right now, and so I don't think this is the time to necessarily dump on employers in that way.

I mean, I know economically it is passed on to the employees, you know, in the long run in the trade-off for wages. But I think that in the first instance right now I think employers would look at it as a problem. So I am not willing to say that, you know.

I mean, I think if we were ever getting to the point where we were looking at a comprehensive solution to, you know, to try and move toward universal coverage, that would be one among many, many elements that could be considered.

Mr. MCCRERY. So you wouldn't reject that out of hand?

Ms. LAV. That would be one among the elements in a comprehensive solution.

Mr. MCCRERY. Thank you very much for that concession, and thank you all very much for the work that you have done and continue to do on this problem of the uninsured. Mr. Patel, I think if for no other reason we should thank you for illustrating very clearly how providing very coherent, cogent information to consumers is possible, and certainly we do that through the Medicare Program, through Medicare+Choice. You have done it for your company. And so it is possible to provide that kind of good information to consumers so they can make good choices.

Thank you all. This hearing is concluded.

[Whereupon, at 2:35 p.m., the hearing was adjourned.]

[Questions submitted from Mr. Doggett to Mr. McClellan and Mr. Weinberger, and their responses follow:]

Council of Economic Advisors, and
U.S. Department of the Treasury
Washington, DC
May 23, 2002

Question 1

I was pleased to hear that the Administration is concerned about the plight of the uninsured, yet I was disappointed to learn that its proposal relies too heavily on individual insurance coverage. In many states, there are no "guaranteed issue" or "community rating" requirements on private insurers, so consumers looking for individual coverage, even with a tax credit, will pay higher than average rates or face denials and exclusions for preexisting conditions.

(a) How does the President's proposal ensure that *affordable* and *comprehensive* policies are available for those uninsured consumers using your proposed tax credit to purchase coverage in the individual health insurance market?

(b) The Kaiser Family Foundation, the Center for Studying Health System Change, Consumers Union and others conclude that without substantial reforms, health coverage in the individual market is often prohibitively expensive or inadequate, particularly for low-income individuals in poor health. Would you support individual health insurance market reforms—such as a "guaranteed issue" requirement already adopted in some states—to ensure that uninsured individuals can actually receive coverage in the individual market?

(c) Please provide me with any evidence you have that refutes the claim made by Dr. Jeff Lemieux, in his testimony at the February 13, 2002 hearing, that "Because [the Administration's proposed] tax credits would cover up to 90 percent of a premium, the Administration's proposal could spawn the development of inferior insurance plans for low-income people."

(d) Please provide any evidence you have that conclusively demonstrates that individuals with low-income or poor health can find comprehensive insurance—with prescription drug coverage and modest cost-sharing—in the individual health insurance market.

1a) Analysis by the Council of Economic Advisers finds that Preferred Provider Organization (PPO) policies with significantly lower premiums are almost always available. These plans are not "first-dollar" plans, but they provide effective health coverage. They typically cover all major types of medical services and treatment, have per person deductibles of $1,000 ($2,000 per family) while also covering preventive and emergency care, they generally provide significant discounts on all prescriptions and in-network services, and they support a range of provider choices. The average premium for a plan of this type was less than $3,000, and was less than $1,000 for young individuals. For lower income uninsured Americans, the proposed health insurance credit thus typically covers more than half of the premium the purchaser would face, and generally covers more than a third. Such affordable policies are substantially less common in states with community rating than in states without such regulation. This analysis is supported by an independent survey of its clients by eHealthInsurance, and by a survey of the actual inquiry and purchasing behavior of persons who seek policies in the individual market by the Coalition for Affordable Health Insurance.

These affordable policies aren't just for those in perfect or good health. Analysis by the National Association of Health Underwrititers (NAHU) found that individual health insurance was available and affordable for those with various chronic conditions, including people with allergies, past surgeries, depression, and heart conditions.

1b) First, this interpretation of the Kaiser study is misguided. The National Association of Health Underwriters (NAHU) participated in that research and has issued a written response disagreeing with Kaiser's interpretation of the data http://www.nahu.org/news/Kaiser-NAHU—Analysis.doc) While Kaiser focuses on the fact that average premium offers are higher for people with chronic or preexisting conditions, the lowest offer that the applicants received in each of the geographic areas that was studied was actually not much higher than the rate for healthy applicants. Except for the one person who was HIV-positive each of the individual received an offer of insurance. Furthermore, many states have high-risk pools that would help those who could not get affordable insurance in the individual market.

This does not suggest that guaranteed issue regulations are effective in expanding coverage. States with guaranteed issue regulations require that insurers write policies for all comers. When coupled with community rating (such as in Maine, New Jersey, New York, and Vermont), this policy means that even those with very high expected health care costs will face the same price as healthy people. The drawback of these policies and many other forms of regulation is that the premiums facing most purchasers may be higher than they would be in the absence of regulation, since the premium collected must be sufficient to cover the expected expenses of the group. Given higher premiums, the healthiest individuals (those with low expected costs) may chose not to buy policies. Regulation thus provides another cause for adverse selection, and a spiraling upward of premiums. In fact, in many states with guaranteed issue the premiums for people with the many of the preexisting conditions studied by Kaiser would face much higher premiums than they would in individual markets without such regulations. According to NAHU, "almost all of the applicants [with chronic conditions] would have faced vastly higher health insurance costs" in states with guaranteed issue and community rating. We are currently studying proposals for improving high-risk pools. These pools canprovide access to insurance for persons with pre-existing conditions without excessively raising costs for healthy persons, and are functioning well now in many states.

1c) The health insurance tax credit proposal has coverage requirements that exceed current HIPAA standards. Our standards would require coverage of catastrophic expenses for in and out patient care. These standards of coverage are consistent with benefits included in a broad health insurance plan and with the plans described in the CEA Health Insurance White Paper. Our standards ensure that policies that did not provide meaningful coverage of serious illness would not be eligible for the credit. Just because the plans are less expensive and do not provide first-dollar coverage does not mean that they are inadequate. Covering large expenses is the most important aspect of insurance, and the health insurance credit would work in conjunction with existing markets to enable millions more to have this kind of protection. Moreover, in addition to protection against the cost of major medical needs many of the policies examined also provide for inexpensive periodic screening and access to discount services should a medical problem arise.

1d) As discussed above, for lower-income Americans, the proposed health insurance credit typically covers more than half of the premium the purchaser would face for insurance that provides access to the private market, and generally covers more than a third. Please refer to the CEA Health Insurance White Paper's appendix on this point. A recent study by the health insurance distributor eHealthInsurance (of people purchasing their policies) found that three-quarters of premiums for individual health insurance plans that it sold were less than $2,000 and three-quarters of family premiums were less than $5,000. Many cost-effective plans include some prescription drug coverage. A Kaiser study, analyzed carefully by the National Association of Health Underwriters, found that even hypothetical applicants with chronic conditions could generally get health insurance in every market they surveyed and that it wasn't that much more expensive. The NAHU analysis is supported by a recent study by the Council for Affordable Health Insurance, Real People, Real Coverage, which surveyed Member companies and found that 81 percent of actual applicants got a policy and 70 percent got their policies at standard rates.

Question 2

In Texas, the Medicaid and SCHIP programs have had some success in ensuring that low-income families have access to medical care, including care for preexisting illnesses and disabilities. In your testimony at the February 13, 2002 hearing, you questioned the accuracy of estimates by Dr. Jon Gruber concerning the cost-effectiveness of tax credits relative to expansions of public insurance.

(a) On a per-insured-individual basis, is the tax credit you propose more or less expensive than an expansion of existing public insurance programs?

(b) How many *previously uninsured* individuals would your proposal cover?

(c) Under your proposal, how many *currently insured* individuals would move from employer (group) coverage to individual (nongroup) coverage?

(d) How do your estimates from the preceding three questions compare to those estimates of proposals to expand public insurance programs?

(e) Please provide any evidence you have to support your answers to the preceding four questions.

2a) A February 2002 Kaiser study estimates the annual public cost of the tax credit per newly insured person is $2,757. There are several reasons that this estimate may be much too high. For example, an author of the Kaiser study noted that he assumes policies cost $10,000 in the individual market. When the authors follow more standard assumptions and allow for access to less expensive health insurance (with premiums more in line with the range we find available in the marketplace), many more previously uninsured people take up health insurance and the cost per newly insured person is only $1,527. Even a narrow expansion of public insurance, such as expanding Medicaid to parents (mandatory Medicaid/CHIP expansion to parents with incomes up to 200% of the Federal poverty level), would be more costly, at $2,974 per newly insured person, than the tax credit proposal. This is true even though Medicaid plans typically provide limited choices of providers and treatments, and documented problems in access to care in many states. And most uninsured Americans would not even be eligible to benefit from that proposal.

2b) Research and independent analysis by Treasury experts indicates that the tax credit will allow 6 million or more Americans who would otherwise be uninsured during the year to gain one or more months of coverage. The credit covers a substantial portion of the premium most currently uninsured people would face in the private individual insurance market, thus increasing participation in and enhancing the efficiency of the individual market for health insurance.

2c) According to the estimates of the Department of Treasury's professional staff, approximately 15 percent of those using the credit would be individuals who move

from employer to individual (nongroup) coverage. This amounts to about 1 percent of those currently with employer coverage. The credit is designed to minimize such crowdout; as noted below, however, crowdout is a substantial problem for Medicaid expansions.

2d) The current estimates of switching from employer to public health insurance coverage in Professor Gruber's most recent work (in reports sponsored by Kaiser and by the Center for Budget and Policy Priorities) and in the larger Kaiser study which he references, most likely underestimates the amount of switching that would occur in a new public insurance expansion. There is a large body of academic economic research that finds considerable amounts of such switching in Medicaid expansions. Much of that research has been done by Professor Gruber himself; in his study that was peer-reviewed and published in an academic journal (David Cutler and Jon Gruber, *Does Public Insurance Crowd Out Private Insurance?, Quarterly Journal of Economics,* 111(2), May 1996, 391–430), Professor Gruber found that at least 48 percent and up to 75 percent of the takeup of Medicaid expansions represented replacement of private health insurance coverage. In a recent review, Kronick and Gilmer conclude that most studies find about 20 percent, on average, of the increase in Medicaid enrollments from past Medicaid expansions came through the crowding out of private insurance. They find relatively more crowdout for Medicaid expansions to relatively high income levels, between 100% and 200% of the federal poverty line than at lower income levels.. Moreover, individual state measures intended to prevent this crowding out were ineffective [Kronick and Gilmer (Jan/Feb 2002) "Insuring low-income adults: Does public coverage crowd out private?" *Health Affairs* 21.1, 225–240]. Thus, it is likely that further Medicaid expansions to higher income levels than those observed in the past would result in even greater crowdout of employer coverage.

Furthermore, measures intended to reduce crowd out in public programs such as requiring a previous lack of insurance, run the risk of encouraging individuals to go without insurance in order to qualify for a benefit. In contrast, the health insurance tax credit provides a broad incentive to immediately purchase insurance before an injury or illness occurs.

Question 3

3. RAND, the Urban Institute, the American Academy of Actuaries, Consumers Union and others, conclude that expansions to MSAs will undermine access to health insurance and lead to the creation of lucrative tax shelters.

(a) Please provide any evidence or quantitative analyses you have that refutes the claim made by Iris Lave, in her testimony during the February 13, 2002 hearing, that the "Administration's proposal would made MSAs more attractive as a tax shelter to healthy, affluent individuals by removing or weakening many safeguards Congress enacted to prevent MSAs from turning into a significant tax shelter opportunity."

(b) What actions do you propose to prevent such exploitation of MSAs?

(c) How many previously uninsured individuals would obtain coverage through the Administration's MSA proposal?

(d) What tis the per-insured-individual cost of the Administration's MSA proposal?

(e) Please provide any evidence you have to support your answers to the preceding three questions.

3a) Lowering the eligible deductible for MSAs will make them more appealing to families at all income levels including moderate income families. Currently about one-third of returns reporting an MSA deduction reported AGI of $50,000 or less. Lowering the deductible will make the MSA plans more attractive to families with moderate health expenses and will thus reduce the possibility that "adverse selection" between MSA plans and conventional insurance will be a problem. Indeed, many Americans are now purchasing plans with deductibles in line with our proposed MSA requirements, and also with coverage of basic and preventive health care, even though they are receiving little assistance from the government with these out-of-pocket costs.

3b) As indicated above, lowering the minimum MSA deductible will most likely make these plans much more attractive to moderate income individuals. The amount that can be contributed to an MSA under the President's proposal cannot exceed the maximum annual deductible, ($2,500 in the case of a single policy). The cap on the maximum contribution limits the extent to which a high income individual will contribute more than a moderate income individual to an MSA and limits the extent to which an MSA can be used as a tax shelter for healthy high income individuals. Rather, the proposal is designed to enable the millions of Americans

who are facing rapidly rising out-of-pocket costs in their insurance plans to get access to the same tax-favored status for those costs as already exists for employer payments toward health insurance premium payments. In addition, according to the Congressional Research Service, higher-income individuals tend to be older and to use more medical service, futher mitigating the extent to which MSAs can be used as a tax shelter. Indeed, since tax-free contributions cannot exceed the policy deductible, the allowable contributions into the MSAs will be reduced (and are more likely to be consumed by even modest use of medical services), rendering MSAs an even less effective tax shelter.

3c) The primary proposal for expanding private health insurance is the refundable, advanceable tax credit, targeted to lower and moderate income families. The primary purpose of the permanent extension and expansion of MSA is to provide additional opportunities to employers and employees to find cost effective ways to provide insurance and choice. We also support proposals to expand public insurance coverage.

3c) Under the current law forty percent of the MSA accounts appear to have been opened by individuals who had been previously uninsured. And all remaining individuals are able to purchase policies with more affordable protection against high expenses, and they also get new tax subsidies for out-of-pocket expenses.

3d) As explained above the primary purpose of the MSA proposal is to provide greater choice and to make coverage more affordable for the millions of Americans with employer coverage who are facing rapidly rising out of pocket costs. In addition, the proposal provides greater tax equity for families who choose cost effective coverage, and families who choose coverage with broad provider networks (and higher out-of-pocket payments) rather than narrow, closed-panel HMO plans with low out-of-pocket costs.

Question 4

Nearly one-quarter of the uninsured have access to employer-sponsored coverage but do not purchase it. Despite a subsidy from their employers, many of these individuals cannot afford the premiums for coverage.

(a) What does the Administration's proposal do to assist these uninsured individuals?

(b) Would you support a tax credit that is available in both the individual and employer-sponsored insurance markets?

4a) First, many of these low-income uninsured individuals will be eligible for the Health Insurance Tax Credit and thus will have the option of purchasing insurance with the credit. Second, we encourage the development of high-risk pools, state-sponsored pools, and other targeted assistance programs. Most states already have such programs, and additional Federal support as envisioned in the House-passed economic stimulus bill would enable those who faced high premiums on the individual market to purchase affordable coverage.

4b) Plans to subsidize the purchase of insurance through employers are very expensive, on top of an unlimited tax deduction worth a total of $120 billion a year already. Several studies have shown that extending a health insurance credit to those who choose to purchase health insurance through their employers is very expensive and does not result in a large decrease in the uninsured per dollar spent. For example, one PPI proposal was estimated by the proponents to cost $40 billion per year Such a credit could result in simply shifting the burden of health insurance premiums from employers to the Federal government.

Question 5

The Administration's proposed FY2003 budget for the Department of Health and Human Services reveals contradictions in spending priorities. While there is a modest increase for Community Health Centers (CHCs) and the National Health Service Corps (NHSC), there are severe cuts to funds for medical professionals' training as well as funds for coordination among health providers. In fact, cuts to the Health Professions Nurse Loan Program and the Community Access Program alone are more than twice as large as the meager funding increase for CHCs and the NHSC. According to the Administration's budget data, that represents approximately $398 million in cuts compared to $158 million in funding increases. This is on top of the Administration's decision to allow significant cuts in Medicaid funding aimed at providers serving large numbers of the uninsured.

(a) At a time when hospitals face significant staff shortages, how do your proposals address the concern that the same Community Health Centers supported by the Administration are unable to find sufficient medical staff?

(b) As the President stated during his February 11 speech at the Medical College of Wisconsin, Medicaid and SCHIP play vital roles in providing medical care to vulnerable families. However, many states face financial constraints that threaten the vitality of these two crucial programs. What actions do you propose the Administration take to help states avoid detrimental cuts in both benefits and eligibility for Medicaid and SCHIP?

What the Congressman refers to as allowing "significant cuts in Medicaid funding aimed at providers serving large numbers of uninsured" is actually the closing of a loop-hole that allowed States to bill the Federal government inappropriately for billions of dollars in excess Federal matching funds. The Medicaid law prohibits State financing practices that increase Federal Medicaid spending beyond statutory matching rates. Recent studies by the Inspector General of the Department of Health and Human Services and by the Congressional Budget Office have identified provider payment policies that have allowed billions of dollars in Federal Medicaid funds to be used for purposes other than that intended including nonhealth expenditure. It was clearly not the intent of Congress as expressed in the Medicaid law to allow states to collect such excess funds. The Administration has taken steps to increase State accountability while also increasing State flexibility, and will continue to work to implement the Medicaid law effectively.

5a) The Administration supports several proposals to encourage people to enter the medical professions and to target more medical professionals to underserved areas. The Budget significantly increases funding to finance scholarships for health professionals from disadvantaged backgrounds, and to encourage additional providers to locate in medically underserved areas. The Budget includes $99 million to help boost the supply of nurses by providing grants to schools of nursing.

5b) Medicaid and SCHIP are valuable programs that bring health insurance to millions of low-income families. The Federal government already pays a large share of the costs of these programs and matches States' spending between 50 and 76 percent for Medicaid and 65 and 83 percent for SCHIP. Finally, in the FY 2003 budget, the Administration has proposed allowing States to keep $3.2 billion in SCHIP funds, which were set to return to the Treasury at the end of this fiscal year and the next. This additional funding will assist states in maintaining their current coverage levels, and will ensure that no state has insufficient Federal matching funds to expand their SCHIP program if they wish to do so. The Administration is eager to work with any state that wants to take advantage of these matching funds, and has proposed a range of initiatives such as the "HIFA Model Waiver" for quick approval of any new state proposals to assist lower income populations.

[Submissions for the record follow:]

Statement of Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries, and Roderick E. Turner, Chairperson, High-Risk Pools Work Group, Task Force on Health Insurance Rate Filing

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to Federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

Introduction

The American Academy of Actuaries appreciates the opportunity to comment on issues related to providing tax credits to decrease the number of uninsured. The Academy was asked to address three issues related to options for expanding health insurance to displaced workers and the expansion of high-risk pools: (1) whether a tax credit would result in a corresponding increase in premiums on the policies that displaced workers could purchase, (2) whether costs would increase for employers and/or insurers if displaced employees were not required to complete their COBRA eligibility before they could purchase a HIPAA qualified health plan in the non-group market using their government subsidy, and (3) the level of funds necessary

to provide a premium buy down for participants in high-risk pools. We will address each of these issues in turn.

Will Insurers Increase Premiums in Response to Tax Credits for Displaced Workers?

Whether insurers will increase premiums in response to providing tax credits for displaced workers depends on the duration of the credit, whether the credit is temporary or will be available to all future displaced workers, and any underwriting restrictions imposed on non-group insurers. Generally, credits of limited duration (e.g. 12 months) likely will have less effect on premiums than credits of longer or unlimited duration. Similarly, credits that are temporary (i.e. available only to workers displaced within a given time frame) will have less effect on premiums than credits available to all future displaced workers. Premiums for non-group insurance issued on a guaranteed basis may be more affected by tax credits than premiums for non-group insurance that is underwritten.

H.R. 622 would provide tax credits equal to 60 percent of premiums for up to 12 months for workers losing their jobs between March 16, 2001 and December 31, 2003. Credits can be applied to the 2002 and 2003 tax years. Non-group coverage is available to displaced workers on a guaranteed issue basis if they are HIPAA eligible,[1] but the only plans available on a guaranteed issue basis are the HIPAA plans in their state of residence. Given this scenario, it is unlikely that insurers would significantly increase premiums if tax credits were provided to these displaced workers.

Most non-group policies are written on an individual policy form. These policies are regulated by state insurance departments that must approve the rate levels. The insurance departments have criteria that these types of policies must meet before the department will approve a rate increase. These criteria are based on the experience of the contract and are compared against required loss ratios (incurred claims divided by earned premiums). They would not allow for a rate increase without justification based on claims experience. Generally, states use past claims experience, but expected future changes in experience may be submitted in some instances. In other words, companies are not free to set the rates at whatever level they choose. Furthermore, all policyholders of similar demographics must be charged the same premium. In other words, one person could not be charged a higher premium than another person with similar demographics simply because he's a displaced worker. For these reasons, individual policies would not see a significant increase in premium if a tax credit were made available.

In some states, policies that are not regulated like individual policies can be sold in the non-group market. These are written using a trust vehicle. The rates on these products can be set by the company without approval from the insurance department. However, much like any other industry, competition will act to keep rates low. If Company A raises its rates above Company B, it risks losing its customers.

Some states do not use a high-risk pool for the HIPAA guaranteed issue mechanism. If for any reason a certain company in such a state would get a disproportionate amount of HIPAA eligibles, the company could affect its overall claims experience enough for it to require an increase in rates. The increase needed would depend upon the proportion of HIPAA eligibles it obtains compared to what it had planned for in its pricing. Even if this rate increase should be needed, it likely would be much lower than the level of the 60 percent tax credit. In these states, both HIPAA eligible and non-eligible people are subject to extra premium surcharges based on their health conditions.

In states that use high-risk pools as the HIPAA mechanism, an increase in the number of insureds in these mechanisms may increase the amount of funding required. This could increase the assessments made to insurance carriers. Currently, the level of assessment is usually around 1 percent of total premiums charged by the carriers. Even if the assessments doubled or tripled over time, which would seem unlikely, the rate increase this would cause would be minimal compared to the 60 percent tax credit.

What is the Impact of Eliminating the Requirement That COBRA Eligibility Be Exhausted Before HIPAA Non-group Eligibility?

Currently, HIPAA requires that individuals exhaust their COBRA eligibility before becoming eligible for a HIPAA qualified plan in the non-group market. One option being considered in conjunction with providing tax credits to displaced workers

[1] The bill changes the prior coverage requirement to be HIPAA eligible from 18 months to 12 months for these people.

is eliminating this requirement. In other words, displaced workers would be allowed to use tax credits for either COBRA coverage or non-group coverage, or they could move to a HIPAA qualified policy at any point during their COBRA coverage period, including immediately at termination of the group coverage.

Currently, COBRA suffers from adverse selection and premiums collected from COBRA participants fall below claims for these participants. In 2000, average COBRA costs exceeded the average costs for active employees by 54 percent.[2] Although people are more likely to elect COBRA coverage if they are unhealthy, demographics can also explain part of the difference in costs between active workers and COBRA participants. COBRA participants are older than active participants,[3] presumably because younger COBRA eligibles can find less expensive coverage in the non-group market, especially if they are healthy. COBRA coverage can be an attractive option, however, for older COBRA eligibles.

An important issue is whether costs would go up, compared to the current environment, for employers and/or non-group insurers if displaced workers were not required to complete their COBRA before being eligible for a HIPAA qualified plan in the non-group market. To help address this question, it is useful to consider the insurance options for workers terminating employment.

Workers terminating employment can be assumed to be in one of two categories based upon health. They either can or cannot qualify for a medically underwritten health insurance policy in the non-group market. For each of these health categories, displaced workers today can go to one of three insurance status categories after losing employment (assuming that they do not get another employer based plan or go to a government program). For people who can pass underwriting, the three insurance categories are: COBRA, a non-group policy, or uninsured. For people who cannot pass underwriting the three insurance categories are: COBRA, HIPAA eligible plan (after exhausting COBRA eligibility), or uninsured.

For people who could qualify for a non-group policy, the effect of a tax credit would be to make coverage more affordable. As a result, many people who chose to go uninsured in the absence of a tax credit would be encouraged to purchase coverage. This influx of relatively more healthy people initially into both COBRA plans and the non-group marketplace would improve the experience of both plans. In addition, in the current environment, some people who would pass underwriting may choose to purchase more limited and inexpensive plans in the non-group market rather than the more expensive COBRA plans which often have richer benefits than people choose to buy in the non-group market. A tax credit may induce some of these people to stay with their COBRA plan rather than go to the non-group market. This may especially occur among younger displaced workers. This would improve the experience of the COBRA plan, but could worsen the non-group experience by removing some of the better risks.

On the other hand, some of the unhealthy people who went uninsured in the absence of a tax credit would now purchase a COBRA plan or a HIPAA eligible plan. This influx of relatively unhealthy people could worsen the experience of both COBRA and HIPAA non-group plans. It is also possible that some relatively unhealthy people currently enrolled in a more limited non-group plan would instead choose to stay in COBRA if it offers more comprehensive coverage. While this would happen with less frequency than the other situations it would shift some of the poorer risks from the HIPAA non-group plans to the COBRA plans.

The net effects on the COBRA and non-group markets of a tax credit for displaced workers, combined with an elimination of the requirement of exhausting COBRA eligibility before HIPAA eligibility, are unclear. In particular, it is unclear whether the influx of healthy participants would offset the higher costs of new unhealthy participants. To answer this question, we would need more information on the relative share of the displaced worker population that is unhealthy and the effect of reducing premium costs on the COBRA and non-group purchasing behavior of displaced workers by health status and other demographics, especially age.

Subsidizing High-Risk Pools

We have been asked to estimate the funds needed to provide a premium buy-down for participants in state high-risk pools. Specifically, how much it would cost the Federal Government to provide a subsidy to all states if the subsidy were predicated on reducing the premium to a level lower than normally associated with high-risk

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[2] Charles D. Spencer & Associates, Inc. "2000 COBRA Survey: One in Five Elect Coverage, Cost is 154% of Active Employee Cost." *Spencer Research Reports* (Chicago, IL, August 25, 2000): 329.04.–1.

[3] Paul Fronstin. "Health Insurance Portability: COBRA Expansions and Job Mobility." EBRI Issue Brief No. 194 (February 1998).

pools today. In particular, H.R. 622 would provide states grants of up to 50 percent of the losses they incur in connection with the operation of a pool, if premiums charged under the pool were restricted to no more than 150 percent of the premium for applicable standard risk rates. Although the Academy could not estimate the specific cost to the Federal Government for such a proposal within the timeframe required for this statement, we can provide some insights into this issue.

Communicating for Agriculture prepares periodic reports that provide detailed information on state risk pools, including operating statistics. According to the most recent report published in 2001, 29 states have created high-risk pools, including 24 that use the risk pool for portability under HIPAA.[4] Total enrollment in these pools in 2001 exceeded 127,000 individuals, and continues to grow. In 2000, risk pool expenditures totaled $691 million, including $651 million in incurred claims and $40 million in administrative costs. Premiums, however, covered only $391 million of expenditures, with the remaining funding coming from assessments on health insurers or other entities ($250 million) and from state appropriations.

State risk pools provide a source of health insurance coverage to individuals who might otherwise be unable to purchase insurance due to health conditions. Premiums charged for coverage under these pools exceed the standard rates for healthy individuals in the non-group market, but fall below what would be charged in the non-group market in states that allow for higher premiums for unhealthy individuals. Most states cap premiums for coverage in high-risk pools at no more than 200 percent of average standard rates. Indeed, for the risk pool to qualify as the HIPAA portability option, premiums must be capped at 200 percent of the standard rates, or less. However, several states cap risk pool premium rates at lower amounts. For instance, Minnesota, Oregon, and California cap premiums at 125 percent of standard rates. Many other states cap premiums at 135 to 150 percent of standard rates.

An important consideration regarding the costs associated with lowering the premium cap is how the costs associated with individuals entering the pool at the lower premiums compare to the costs for those already entering the pool at the higher premiums. If premiums are reduced, some individuals who do not buy a high-risk pool product due to the expense would likely buy one in the future. It is possible that the experience of these people would not be as bad as the current high-risk pool population. They would, however, be expected to generate claims in excess of their premium in most cases. This would create additional dollar losses for the program that would not have existed before the subsidy. To induce states to lower their premium caps, it is likely that an additional subsidy would be needed to cover these new losses, as well as the subsidy needed for the current population.

One potential method of assessing the extent to which experience of the new entrants would differ from the current pool is to examine how the loss ratios of risk pools with higher premium caps differ from loss ratios of risk pools with lower premium caps. Presumably, if lower premium caps encourage a broader, relatively more healthy, risk pool, loss ratios for states with low premium caps would be lower than those with high premium caps. An examination of loss ratios for state risk pools, however, reveals no clear trend between loss ratios and premium cap percentages. The lack of any discernable trend may reflect differences in the calculation of the base rates to which the premium cap percentages are applied. In addition, some state pools actually charge rates lower than the maximums prescribed, some states charge different rates to HIPAA-eligible vs. other pool insureds, and some states have a low-income subsidy program. Other differences may also contribute to the lack of correlation between loss ratios and premium caps, including how eligibility for the pool is defined and whether the enrollment is capped. All of these differences would need to be considered when determining the relative risk of new entrants if premiums were lowered.

Estimating the Federal subsidy required to encourage risk pools to lower their premium caps would also need to consider additional factors. First, the incremental growth in pool enrollment that may be experienced when premium caps are reduced would need to be estimated. These estimates need to recognize that even without changes in premium cap percentages, enrollment in most risk pools is growing, in part due to the economic downturn. Perhaps more important, enrollment growth would also need to be estimated for pools that have capped enrollment. Second, increases in health care costs will further increase the difference between premiums paid to risk pools and the claims incurred. Finally, how the Federal Government defines risk-pool losses will affect the amount of subsidy. Defining losses broadly as the difference between claims and administrative costs less premiums will require

[4] Communicating for Agriculture, Inc. *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, Fifteenth Edition, 2001/2002, Fergus Falls, MN: Communicating for Agriculture & the Self-Employed (2001).

higher Federal subsidies than if losses are defined as net of assessments. However, the more narrow definition of loss will penalize states that partly fund their risk pools through assessments rather than solely through state appropriations, which might lead them to reduce or modify their assessment methodology.

Statement of the Communicating for Agriculture and the Self-Employed, Inc., Fergus Falls, Minnesota

COMMUNICATING FOR AGRICULTURE URGES CONGRESSIONAL SUPPORT FOR REFUNDABLE TAX CREDITS FOR HEALTH INSURANCE

CA Calls on Congress to also Extend Health Insurance Deductions for Individuals; Strengthen Association Health Plans; Support Risk Pools; Increase Competition

WASHINGTON, D.C.—In calling for support for the President's position on refundable, advanceable tax credits for the purchase of health insurance, Wayne Nelson, president of Communicating for Agriculture and the Self-Employed (CA), reminded Congress that any legislative solution must address not only the problems of those who have employer-based insurance, but also those who purchase individual health insurance policies.

"We have long supported refundable tax credits to assist those nearly 40 million Americans who are now uninsured," said Nelson. "And, a great many of this 40 million will not have access to employer-based insurance and must look for assistance in the individual marketplace."

Nelson said his organization, which represents farmers, ranchers and small rural businesses all across the country, initiated a Campaign for Consumer Choice and Lower Health Costs last year specifically designed to support legislative changes that would level the playing field for those Americans who purchase individual health care coverage. In addition to refundable tax credits, the Campaign calls for:

- Extending the health insurance deduction to 100 percent for all self-employed *AND* individuals who pay for their own insurance;
- Strengthening and expanding association health plans for individuals;
- Creating risk pools serving as health safety nets in every state to support workable access guarantees for those who otherwise would not be covered in the individual insurance market;
- Continuation and expansion of MSA accounts to offer more choices and help lower health costs for individuals and the self-employed; and
- Restoring competition and choice to make health insurance more affordable for individuals and the self-employed.

Communicating for Agriculture and the Self-Employed is a 30-year-old national, non-profit, rural membership organization long known for its work on health care reform, tax reform, and rural and agricultural policy issues. CA is made up of farmers, ranchers, small businesses and other self-employed members in all 50 states. For more information on CA contact the Web site at *SelfEmployedCountry.org*.

Statement of Jonathan Gruber, Ph.D., Professor of Economics, Massachusetts Institute of Technology, Cambridge, Massachusetts

I am pleased to have this opportunity to provide an analysis of the implications of the President's proposed health insurance tax credit for health insurance coverage and public sector costs. I am a Professor of Economics at MIT and have been doing research in health economics for more than a decade. I am an Associate Editor of the Journal of Health Economics, the leading journal of the Health Economics field, and a co-editor of the Journal of Public Economics, the leading journal in the field of taxation and public finance. I am also a Faculty Research Fellow at the National Bureau of Economic Research, where I direct the Program on Children.

Over the past few years, through work with the Kaiser Family Foundation, I have developed a microsimulation model to analyze the implications of tax credits for health insurance. In this testimony, I would like to discuss the results of using this model to analyze the President's budget proposal. These results are part of an ongoing project with the Kaiser Foundation to estimate the effects of tax credits and

public program expansions designed to expand coverage for the uninsured; the full results from that project will be publicly released soon.

Background on the Model

The results that I discuss below come from a very detailed microsimulation model of health insurance decisions. This model takes what the we know about individual, firm, and insurer behavior, and uses that to predict what will happen to health insurance coverage, and public sector costs, when insurance policy changes. This approach is broadly similar to the approach used by the Congressional Budget Office or Joint Tax Committee in scoring legislation, although there are of course many differences in the particulars of execution.

This model takes as its base the 1999 Current Population Survey, updated to 2001 dollars. This nationally representative survey that allows me to estimate, for the entire nation, the impact of policies such as tax credits. On to that data I have matched information on the cost of both group and nongroup insurance from publicly available sources, in order to estimate the baseline from which policy changes would move us.

The core of the model is a set of "behavioral responses" which map changes in insurance prices (due to subsidies) to individual, firm, and market behavior. These behavioral responses are developed through a careful reading of the health economics literature, incorporating both my research and that of others, and through careful consultation with a range of experts in academia, the private sector, and the government.

This model has been used extensively to analyze a variety of tax policy options. The results from some of this analysis was presented in "Tax Subsidies for Health Insurance: Costs and Benefits," Health Affairs, 19(1), January/February 2000, pages 72–85. The model has been continually developed and updated since that earlier work.

The President's Proposal

The purpose of this letter is to present my results from analyzing the President's proposal for a health insurance tax credit in his FY 2003 budget. I am not analyzing or incorporating any other of the President's health proposals. The salient details of the tax credit are:

- The credit is a refundable tax credit towards the purchase of nongroup health insurance. It may not be used for public or employer-sponsored health insurance purchases.
- For single filers, there is a credit of up to 90% of the costs of the nongroup plan, with a maximum credit amount of $1,000. This credit amount is available up to $15,000 of modified AGI; it then phases out fully by $30,000 of AGI.
- For joint filers, there is a credit of up to 90% of the costs of a nongroup plan, with a maximum credit of $1,000 per adult and $500 per child, up to $3,000 total. This credit is fully available up to $25,000 of family income, and then phases out fully by $40,000 of family income (if only one adult purchases insurance) or $60,000 of income (if more than one adult or any children purchase insurance).
- The credit can be used either retrospectively or in advance; in the latter case, the Treasury Department would pay the credit directly to the insurer.
- There are future provisions to allow the credit to be used to purchase into group insurance pools. I do not model those here, as they presume the availability of pooling mechanisms that would need to be developed for this purpose. I focus only on the effectiveness of this credit in the context of the nongroup insurance market.

This credit structure is very similar to that analyzed in my earlier work. In that work, I raised the crucial issue of advanceability. Since most of the uninsured have low incomes, and low asset holdings, it will be quite hard for them to pay in advance the costs of insurance and then be reimbursed for those costs more than one year later when they get their tax refunds. The President proposes to solve this problem through the advanceable credit described above.

An important question is how effective this approach will be in practice. There are two reasons to be skeptical that this will be fully effective. First, if individuals who claim the credit in advance, and whose incomes then turn out to be higher than expected, are asked to "repay" the advance credit amount at tax time, this could deter many individuals from claiming advance credits. Second, even if there is no "reconciliation" of this form, there may be wariness about using advance credits. The experience of the Earned Income Tax Credit (EITC) is informative here. Advance payment of the EITC is available, and for almost all taxpayers this would be

more sensible than getting the refund in a lump sum the next year. Moreover, safeguards are in place so that individuals are very unlikely to "overclaim" their EITC (e.g. that there is little odds of a reconciliation problem). Yet, fewer than 1% of EITC claimants do claim their credit in advance.

As a result of these limitations, I find it highly unlikely that advanceability will be fully effective. In my estimates below, I therefore make the assumption that it is half-effective: that is, for half of individuals, the credit is treated as advanceable, but for the other half, it is not.

Results of Analysis

The results of this analysis are presented in Table 1, which shows the aggregate impacts of the tax credit. The first row of the table shows the aggregate costs. The next panel shows the takeup (in persons in the first column, and as a percent of group size in the second column) and costs by previous (before policy change) insurance status groups. The next panel shows the change in the size of each insurance group due to the policy. The final row shows the revenue cost per newly insured person.

My analysis suggests that:

- This policy will cost $5.2 billion per year.
- There will be 10.5 million persons who takeup the credit. Of those, roughly one-third (3.3. million) are the uninsured.
- There will be a very sizeable movement of almost 4 million persons out of employer-provided insurance. A total of 2.4 million persons will be dropped from group insurance by their employers. Of those, one million will takeup nongroup insurance, but 1.4 million will become uninsured. And 1.5 million persons will switch from their group policies to nongroup policies.
- With 3.3 million previously uninsured taking the credit, but 1.4 million persons who previously had employer-provided coverage becoming uninsured, there will be a net reduction in the number of uninsured of 1.9 million.
- The net result is a public cost per newly insured person of almost $2,800.

Thus, the tax credit does have its intended effect of significantly increasing the purchase of nongroup insurance by the uninsured. But it also has an unintended effect of slightly eroding the group insurance market, so that the net reduction in the uninsured is fewer than 2 million, or 5% of the existing number of uninsured.

Sensitivity to Insurance Cost Assumptions

One of the key debating points about those modeling tax credits for health insurance is the extent to which individuals will find low cost nongroup plans on which they can use their tax credit. This is an important issue because the costs of nongroup insurance plans are so high. For a 40 year old male in excellent health, the average cost of nongroup insurance is roughly $2,000 per year. But these costs rise dramatically with age and poor health status. Indeed, in my data, for the typical uninsured family the cost of a nongroup policy is estimated to be roughly $10,000.

My estimates assume that individuals and families who purchase nongroup insurance will pay these average market prices for that insurance. But some claim that the individuals will use this credit to avail themselves of new, low cost insurance options. This claim is hard to evaluate without the policy actually being passed, but it merits consideration.

Thus, Table 2 summarizes the results of my analysis under the base case, and under two alternative assumptions about nongroup policy costs. The first assumption is that half of all persons are able to obtain nongroup policies at 25% below the average cost in the market. The second is that half of all persons are able to obtain policies at 50% below their average cost in the market. This second assumption in particular is fairly extreme. Even for a healthy 40 year old male, obtaining a policy for $1,000 would involve a deductible on the order of $3,000, a 20% copayment, a $5,000 out of pocket maximum, 20% coinsurance on drug costs, and no coverage of mental health or other professional services (according to actuarial analysis done for the forthcoming Kaiser Family Foundation project).

This first two columns of the table shows that there would be a modest effect of a 25% premium reduction. The reduction in the number of uninsured increases from 1.9 to 2.2 million, with only a small increase in costs to $5.4 billion per year. But there is a much larger effect of assuming a 50% premium reduction, as shown in the second two columns. In that case, the number of uninsured falls by 3.6 million, with costs rising to $6 billion per year. There is also a much larger displacement of the employer insured, with the number of employer insured falling by 6.9 million (1.9 million of whom end up uninsured).

Discussion

The results from this analysis suggest the advantages and disadvantages of the President's tax credit proposal. The main advantage is that this proposal delivers benefits to a large number of taxpayers (at least 10 million) at a relatively low cost ($5 billion per year). This helps reduce the inequities of the existing system of tax subsidies, whereby those with employer-provided insurance (and the self-employed) receive tax subsidized insurance and others do not.

The main disadvantage is that this policy has a very modest impact on the number of uninsured in the U.S. My central estimates suggest that the number of uninsured will be reduced by fewer than 2 million, or 5% of the existing number of uninsured. This amount equals roughly the rise in the uninsured estimated to be caused by the recent rise in unemployment, according to a recent analysis by myself and the Kaiser Family Foundation (available at *http://www.kff.org/content/2001/6011/6011.pdf*). Thus, this proposal on net does not reduce the number of uninsured from where it was one year ago.

The other disadvantage of this approach is that it displaces, rather than supplementing, the group insurance market. The group insurance market remains the most effective way to delivering insurance benefits, through its use of large pools to minimize the variation in health risk to insurers. My estimates suggest that for every one person gaining insurance coverage, two persons will be leaving the group insurance market.

The limited impacts of this credit should not be surprising, given that it covers such a small share of the costs of insurance in the nongroup market. As a result, this credit does much more to help pay the costs of those already buying insurance than to raise insurance coverage; roughly two-thirds of those taking the credit in all my analyses are those who already have private insurance coverage.

A central question is the extent to which the effectiveness of this credit will be boosted by the availability of "low cost" insurance options. As shown above, if half the population is able to find an insurance policy that lowers the cost of their insurance by half, the reduction in the uninsured almost doubles at very little additional cost. But I am quite skeptical of claims that low cost policies can raise the effectiveness of this tax credit, for two reasons. First, if such low cost policies exist today, why are there still 40 million uninsured Americans? The answer is that most Americans do not want catastrophic-type coverage; they apparently would rather be uninsured than buy low premium, high out-of-pocket-cost policies. The enormous out of pocket costs that are typically associated with these low cost policies make them unattractive to the uninsured.

Second, the very reason that such policies can be low cost is that they are only purchased by the very healthiest individuals for whom they are affordable; in other words, there is "virtuous selection," as opposed to "adverse selection." If a credit allows less healthy persons to purchase these policies, they will have to raise their prices to adjust for this higher cost risk pool. In other words, low prices on these policies today do not guarantee low prices in the world of a health insurance tax credit; it seems likely that those low price policies will increase in price once more "typical" persons are buying them.

I would also like to emphasize the central nature of two aspects of this tax credit policy. First, this credit is refundable. Roughly half of the uninsured do not pay taxes, so that a nonrefundable credit does them no good. Indeed, my model suggests that the number of uninsured would fall by less than half a million persons if this credit were not made refundable. Given debates over tax credit refundability in other contexts, it is important to recognize the importance of making any health insurance credit refundable.

Second, this credit is very tightly targeted to the lowest income families in which most uninsured reside. Increases in income limits would do very little in terms of increasing the impact of this policy, but would dramatically raise costs. For example, I have reestimated this model for the same proposal as that included in the President's budget, but raising all income limits by 50% (e.g. the credit for singles phases out from incomes of $22,500 to $45,000). The results of doing so, illustrated in Table 3, are striking. The takeup by the previously uninsured goes up from 3.3 to almost 4 million. But there is a very large rise in the erosion of the group market, including an increase in those moving from group insurance to uninsured of over 600,000. As a result, there is almost no impact on the net change in insurance coverage; the reduction in the number of uninsured goes only from 1.9 to 1.95 million. But costs go up by over one-third, to almost $7 billion per year.

Thus, raising the income limits actually had pernicious effects on the insurance market on net: the reduction in the uninsured was unchanged, but there was a much larger net movement from group to nongroup insurance. As a result, the total cost of the policy rose by over one-third with no gain in insurance coverage. This

finding highlights how important it is to keep tax policies tightly targeted. If the tight targeting proposed by the President is loosened at all as this bill becomes law, it will greatly reduce its public policy benefits.

Table 1: Refundable Credit for Non-Group Insurance

	Number of Persons (Millions)	Percent of Insurance Category	Net Cost ($2001 Millions)
Total Cost in $2001			5231
Total Takeup of Subsidy	10.47	4.4	—
Previously non-group	4.25	43	3066
Previously uninsured	3.3	7.5	3263
Previously employer-insured	2.57	1.6	−958
Previously Medicaid	0.35	1.9	−140
Total Change in Population Size			
Non-group	6.19	62.6	—
Uninsured	**−1.89**	**−4.3**	—
Employer-Insured	−3.99	−2.5	—
Firm dropped to non-group	1.03	0.7	—
Firm dropped to uninsured	1.36	0.9	—
Switch to non-group	1.54	1	—
Uninsured due to decreased Contributions	0.05	0	—
Medicaid	−0.35	−1.9	—
Cost per Newly Insured ($2001)			$2772

Table 2: Refundable Credit for Non-Group Insurance—25% and 50% Premium Reductions

	25% Premium Reduction		**50% Premium Reduction**	
	Number of Persons (Millions)	Net Cost ($2001 Millions)	Number of Persons (Millions)	Net Cost ($2001 Millions)
Total Cost in $2001		5404		6017
Total Takeup of Subsidy	11.91	—	15.45	—
Previously non-group	4.37	3119	4.48	3128
Previously uninsured	3.84	3755	5.56	4833
Previously employer-insured	3.26	−1253	4.79	−1546
Previously Medicaid	0.44	−217	0.63	−398
Total Change in Population Size				
Non-group	7.4	—	10.68	—
Uninsured	**−2.16**	—	**−3.62**	—
Employer-Insured	−5.01	—	−6.9	—
Firm dropped to non-group	1.7	—	2.55	—
Firm dropped to uninsured	1.63	—	1.88	—

Table 2: Refundable Credit for Non-Group Insurance—25% and 50% Premium Reductions—Continued

	25% Premium Reduction		50% Premium Reduction	
	Number of Persons (Millions)	Net Cost ($2001 Millions)	Number of Persons (Millions)	Net Cost ($2001 Millions)
Switch to non-group	1.58	—	2.3	—
Uninsured due to decreased Contributions	0.05	—	0.06	—
Medicaid	−0.44	—	−0.63	—
Cost per Newly Insured ($2001)		$2503		$1663

Table 3: Refundable Credit for Non-Group Insurance High Phaseout Scenario: 50% Increase in Phaseout Levels

	Number of Persons (Millions)	Percent of Insurance Category	Net Cost ($2001 Millions)
Total Cost in $2001			6981
Total Takeup of Subsidy	12.47	5.3	—
Previously non-group	4.58	46.3	3806
Previously uninsured	3.98	9.1	4234
Previously employer-insured	3.54	2.2	−922
Previously Medicaid	0.37	2	−137
Total Change in Population Size			
Non-group	7.86	79.6	—
Uninsured	**−1.95**	**−4.4**	—
Employer-Insured	−5.6	−3.5	—
Firm dropped to non-group	1.64	1	—
Firm dropped to uninsured	1.97	1.2	—
Switch to non-group	1.91	1.2	—
Uninsured due to decreased Contributions	0.07	0	—
Medicaid	−0.37	−2	—
Cost per Newly Insured ($2001)			$3581

Statement of Mary R. Grealy, President, Healthcare Leadership Council

The Healthcare Leadership Council (HLC) is a coalition of chief executives of the Nation's leading health care companies and organizations representing all sectors of health care. Our members are committed to advancing a market-based health care system that values innovation and provides affordable, high-quality health care. HLC would like to thank the Committee for focusing today on tax credits for the uninsured and for the opportunity to submit this statement.

The HLC believes there is no greater health care priority in this Nation than the over 40 million individuals who are without health care coverage. The health consequences to those not having health insurance are well documented. They tend to get sick more often because they do not receive the preventive and diagnostic care

that so many of us take for granted. They miss more time on the job and statistics tell us they will die too early. In addition, we must consider the consequences to our Nation's overall well-being from having such a large population of uninsured, including productivity losses and the strain on health providers caused by uncompensated care. The President and the Congress should be highly commended for giving the issue of the uninsured the attention it deserves.

The HLC supports a three-pronged approach for the uninsured. This includes: (1) refundable tax incentives to encourage the purchase of insurance of the consumer's choice, including employer-offered coverage; (2) improvements in the current Medicaid program and State Children's Health Insurance Program (S–CHIP), including enrollment of those currently eligible and using program dollars to expand private coverage; and (3) increased efforts to facilitate awareness of the importance and availability of health insurance, especially among small businesses.

President Bush has demonstrated a strong commitment to the uninsured by including more than $90 billion in his recent budget to begin mapping the way to coverage for a significant number of the uninsured. The majority of this funding would provide a health tax credit to help families purchase insurance plans in the non-group insurance market. The HLC believes this is a significant first step toward a universal, market-based health care system. It is our goal to work with the Administration and Congress to encourage the development and expansion of this proposal. The HLC also supports the President's proposed medical savings account and flexible spending account amendments which will make these products more effective coverage options.

These proposals, as well as proposals to increase funding for community health centers, assist hard-to-insure families and individuals in purchasing coverage from state risk pools, and maximize use of existing S–CHIP funds, are all indicative of the Administration's resolve to strip away the diverse array of access barriers encountered by the uninsured.

The members of HLC are committed, as well, to raising awareness of this national problem and bringing solutions to those lacking health coverage. In June of 2001, we formed the national Health Access America campaign because we believe that all Americans should have access to today's modern medical miracles and life-enhancing technologies and treatments. Under this campaign, HLC members have committed their leadership, energies and resources to help solve the Nation's uninsured crisis.

In addition to our Health Access America campaign, the HLC continues to highlight model programs throughout the country that promote health coverage and access, presenting them with our "Honor Roll For Coverage" award. In 2001, we recognized Virginia's model waiver program, that allows S–CHIP funds to be used for employer coverage, and South Carolina's Communi-I-Care program, which provides care to individuals who are not eligible for public assistance or employer-based insurance. In May 2002, the HLC will present our fifth Honor Roll for Coverage award to Sacramento County in California. Sacramento has based its program on that of a previous HLC Honor Roll awardee, and works with small employers to increase access to coverage for their employees.

The HLC is also committing resources to continued research on the characteristics of the uninsured and potential solutions to reduce the number of uninsured. Some of our findings and observations that will bring a critical perspective to the topic of today's hearing include:

Characteristics of the Uninsured. Four out of every five uninsured persons are in families with at least one employed family member. In other words, 15 percent of the Nation's population is uninsured and only a small percent of these people—16 percent—are in families where no members are employed. Of the uninsured in working families, 39 percent turn down an offer of insurance from an employer—usually because they can not afford it, and 61 percent are not offered employer insurance. These striking figures suggest that refundable tax incentives could serve to bridge the premium gap between what an employer and employee are each able to pay for a health insurance policy. Such tax incentives could encourage many employers not now offering coverage to do so, and will also aid those not offered health insurance by their employer.

True tax equity. For low income workers, the current levels of tax credits being discussed for the purchase of non-group insurance are greater than the value of the current exclusion from Federal income taxes of average health insurance benefits paid by an employer. A commonly-discussed health insurance tax credit amount for families is $3,000. However, for families with income levels between 200 to 300 percent of the Federal poverty level ($35,000 to $53,000 for a family of four), the tax exclusion for employer-paid health insurance is worth only about $661. For families

between 300 and 400 percent of poverty, the exclusion is worth only about $802. Thus a refundable health tax credit would be particularly valuable for low income workers, even those who are offered insurance by their employers.

Maintenance of employer offers of insurance. The cost of tax incentive proposals to reduce the uninsured presents a challenge. This is especially true for proposals that allow tax incentives to be used for those with employer offers of insurance. This is because legislative "scorers" (Joint Tax Committee, Congressional Budget Office, Office of Management and Budget) incorporate assumptions that many of those already receiving employer-based insurance will be "bought out" with Federal dollars and current employer expenditures will cease. However, employers are paying for benefits given to workers as a form of wages. The extent to which employers will reduce their contributions toward health insurance for employees when a subsidy such as a tax credit is offered can be demonstrated by looking at economic studies examining experiences with wage subsidies. HLC has examined two studies (Katz, 1996 and Witte et. al, 1998) in which general wage subsidies and child care subsidies from the government did not reduce overall benefit spending efforts by employers.

An additional consideration in regard to employer maintenance of effort for health benefits is raised when targeting credits to only lower income employees. It is unlikely that employers would discriminate by reducing their premium contributions only for low-income workers receiving the subsidy, while maintaining the current contributions for higher income workers not eligible for the subsidy.

Limits of the S–CHIP and Medicaid programs. Evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through the S–CHIP and Medicaid programs. While S–CHIP and Medicaid have proven valuable for providing health care to very low income populations, only about half of individuals currently eligible for Medicaid and S–CHIP actually participate. A number of reasons have been cited for low participation rates including the fact that participation rates of means-tested public insurance programs decline as incomes rise. A large number of those not participating are those who became eligible upon the inception of S–CHIP, when more children in families with higher income levels were offered public insurance. This pattern of lower participation among higher income persons is also evident in other government health care subsidy programs, including the Qualified Medicare Beneficiaries (QMBS) and Specified Low-Income Medicare Beneficiaries (SLMBs) programs. Researchers have concluded that substantial outreach is necessary to overcome barriers to participation, such as the possible stigma associated with public programs.

These data suggest that eligibility alone, without considerable investment to remove existing barriers to participation, will not efficiently increase insurance coverage. Many eligible individuals in the higher income categories of Medicaid and S–CHIP, as well as income categories under consideration for Medicaid and S–CHIP expansions, are connected to the workforce. Therefore solutions involving employer insurance may be more effective in increasing coverage rates for these populations.

Careful targeting. All Americans deserve access to affordable health coverage options. However, current budget constraints may require a phased-in approach for covering all the uninsured. As coverage rates increase, the marginal cost of each newly-insured individual increases because greater numbers of the uninsured are dispersed within populations of already covered persons. However, carefully targeted tax incentives to reach limited populations can bring down the costs per newly-insured. For example, targeting the credits toward populations less likely to already have coverage such as low-income families or workers in small businesses or even a combination of these can help to reduce the cost of such an approach and still reach many currently-uninsured persons. The HLC has modeled a number of targeted tax incentive policies and would be happy to share them with the Committee.

Another population to consider targeting with tax incentives is dependents of lower income workers not eligible for S–CHIP or Medicaid. Small and medium sized businesses offering insurance to their employees contribute, on average, 48 percent of the premium amount for employees, and only about 24 percent for dependents of employees. Not surprisingly, in many cases, low income employees frequently cannot afford insurance for their dependents. Policy makers should take this fact into account when designing targeted tax incentives policies for the uninsured.

Conclusion

Mr. Chairman, the Healthcare Leadership Council appreciates your substantial efforts on the uninsured this past year and applauds you for your ongoing work to

find ways to solve the Nation's most pressing health care issue. The uninsured must be our national health care priority for 2002. This multi-faceted problem will require a variety of approaches and we look forward to working with you and the Administration to find concrete solutions.

Thank you for the opportunity to share HLC's views today. We stand ready to assist this Committee in any way as you work toward solutions that will allow all Americans to enjoy the benefits of our Nation's health care system.

Statement of the National Association for the Self-Employed

The National Association for the Self-Employed (NASE) is pleased to have the opportunity to submit the following statement for the official record. We thank Chairman Bill Thomas, Ranking Member Charles Rangel, and Members of the Committee for addressing the issue of health care tax credits.

The National Association for the Self-Employed (NASE) is a bipartisan, non-profit small business trade association founded in 1981 that represents over 200,000 members nationwide. Ninety percent (90%) of our membership consists of small businesses with five (5) or fewer employees. The NASE's primary goal is to help the self-employed meet the challenges of making their businesses successful and one of the self-employed community's largest challenges is obtaining access to affordable health coverage.

Below are various statistics of which I am certain the Members of this Committee and witnesses of this panel are aware.

- There are approximately 24 million small businesses in our Nation. They account for 99.7 percent of America's employers and employ 53 percent of the private workforce.
- There are approximately 43 million uninsured Americans in our Nation and that number increases as the unemployment rate increases. Approximately 62% or 24.5 million of the uninsured have a family head that is self-employed or working in a firm with fewer than 100 employees. (Source: Employee Benefit Research Institute data from the Census Bureau's March 1998 Current Population Survey).
- According to the General Accounting Office's October 2001 report on Private Health Insurance, only 36% of employers with fewer than 10 workers offered health coverage to their employees despite the fact that they represent about 61% of small employer establishments. The report cited the primary reason small employers gave for not offering coverage was cost.

These statistics are telling us is that Congress and the Administration must focus their efforts on small business access to **affordable** health care in order to effectively reduce the number of uninsured in our Nation.

The National Association for the Self-Employed strongly believe that health care tax incentives including tax deductions and tax credits for the self-employed are necessary to provide affordable health coverage.

Self-Employment Health Insurance Tax Deduction

Tax credits and deductions are a viable solution to begin addressing the existing insurance inequities in the Tax Code. A new idea in tax policy is to create parity between employer provided health insurance and health insurance for the self-employed.

Currently, premiums for an employer who sponsors health coverage for his/her employees are not subject to FICA withholding tax (Social Security and Medicare). Employees that utilize an employer sponsored health plan are also not subject to FICA withholding tax (Social Security and Medicare) and thus enjoy health insurance premiums free from income tax and FICA tax. However, self-employed individuals are subject to the self-employment tax (Social Security and Medicare) on health insurance premiums for themselves and their dependents. The result is that the self-employed pay a tax premium on health insurance of up to 15.3% of the cost of that insurance.

To explain this further here is an example:

John works for Widget Company, a small business with only two employees, including the owner. Widget Company provides employer paid health insurance for it's two employees and their dependents. Widget Company appropriately deducts in total, the cost of the employee health insurance on its business tax return as an "ordinary and necessary" business expense as authorized by the Internal Revenue

Code. Further, none of the health insurance premiums are included in the employee's W–2 income and are therefore free from Federal income tax and FICA withholding tax (Social Security and Medicare). The preferential tax treatment of the health insurance premiums provides a significant tax benefit Widget Company and for employee John. Since John does not include the value of the premiums anywhere in his taxable income, he has received a tax benefit of up to 35% of the insurance cost. Note that Widget Company has not paid any income tax or FICA tax on the premiums either.

John leaves Widget Company and becomes self-employed doing the same types of business processes he did for Widget. The cost of health insurance premiums are not deductible as an "ordinary and necessary" business expense and are therefore subject to Federal income tax and self-employment tax (Social Security and Medicare). The health insurance premiums may qualify for a limited deduction from gross income as a "self-employed health insurance deduction" on page 1 of John's individual income tax return (Form 1040). Even if John can utilize the income tax deduction for 70% of the premiums, he must still pay income tax on 30% of the premiums. In addition, John must pay self-employment tax (Social Security and Medicare) on 100% of the premiums. In total John has a tax detriment for purchasing health insurance of up to 25% of the premium cost.

This process is another example of the current inequities in the Tax Code that are detrimental to the self-employed. By allowing the self-employed to claim their health care premiums as a business expense the net cost health insurance premiums will be reduced by up to 25%, which is a significant reduction. Note that allowing premiums to be an "ordinary" business expense would not affect current income tax deductions after 2002.

Acceleration of 100% Deductibility of Health Insurance

Acceleration of 100% deductibility of health insurance for the self-employed is another important tax deduction that would greatly assist the self-employed community. Currently it will be phased in by 2003. However, the NASE feels that sooner is better than later. We would like to see 100% deductibility available in years beginning after 2001.

Refundable Tax Credit

A tax incentive such as a refundable tax credit should be made available for the purchase of health insurance coverage for all individuals. It would cover 100% of the cost of health insurance coverage for up to $500 for individuals and $1,000 for families. The refundable tax credit should be made available to those individuals whose employer does not sponsor or contribute to an individual or family health plan for their employees and for the unemployed. Self-employed individuals would have the opportunity to utilize either the self-employed health insurance deduction or the refundable tax credit but not both.

Conclusion

We here in Washington D.C. discuss issues through facts, figures and legislative solutions. But there is also a personal face to the current health care issues that plague the self-employed and small business community. Recently, NASE member, Lance Kisby, a Pediatric Dentist in Needham, Massachusetts had contacted the NASE office to tell his story on how the high costs of health care are affecting his small business. Dr. Kisby informed us that his health insurance premiums have changed from $522 per month to $945 per month. These increases have forced him to pass along some of the cost to his patients by raising his fees 5% and to work longer hours to cover the loss of profit due to the higher health care costs. Dr. Kisby remarks, "As a self-employed person, I recognize that there are so many hours in a week and that I can only raise my fees so much and still be competitive while also having money to feed my family."

Dr. Kisby's story characterizes the plight the self-employed face in attempting to acquire and provide affordable health coverage for themselves and their employees. Health care tax incentives would go a long way to solve not only the problem of small business access to affordable health care but to also alleviate the growing ranks of the uninsured.

Statement of Sister Karin Dufault, Ph.D., Chair of the Board, Providence Health System; Seattle, Washington; PeaceHealth, Bellevue, Washington; Providence Services, Spokane, Washington; and Swedish Health Services, Seattle, Washington

Thank you, Chairman Thomas and Members of the Committee for accepting our statement on the issue of health care tax credits to decrease the numbers of uninsured individuals and families in the United States. As a coalition of non-profit health care systems with hospitals, nursing homes, physician groups, a health plan and other facilities in the states of Alaska, Washington, Oregon, Montana and California, we are gravely concerned about the harmful effects of so many people in the communities we serve who live without adequate access to basic health care because they are uninsured or under-insured.

According to recent estimates, as many as 21 percent of Californians have no health insurance; Montana and Alaska's rates of uninsured are nearly 20 percent, and Oregon and Washington's rates of uninsured are at 14 and 13 percent, respectively.[i] These estimates do not account for likely increases as a result of the economic recession and the corresponding rash of job layoffs in our communities.

As health care providers, we experience the impact of this problem on a daily basis, as many of the uninsured receive their only health care in our emergency departments. While it goes without saying that this is not good medicine for these individuals, the societal implications of this situation are even more profound: many of our emergency rooms are functioning now at full capacity 24 hours a day and are increasingly forced to divert patients to other hospitals nearby as a result of too much patient volume. The increasing number of uninsured individuals seeking care in hospital emergency rooms threatens access for everyone who needs serious emergency care, regardless of health insurance status.

As such, we applaud President Bush and the Members of this Committee for your efforts to address this issue that is critical to our communities and the people we serve. We support any initiative that will achieve greater coverage in a manner that is equitable for all Americans and is an efficient use of government resources.

However, our support for the Bush Administration's tax credit proposal as a mechanism to expand coverage must be qualified by some critical concerns:

1) We believe the amount of the tax credit proposed by the White House will not lead to significantly expanded coverage for low-income uninsured; in order to truly reach the most people, the tax credit should be considered as one component of a package of policy changes, along with an expansion of eligibility and Federal funding for public health insurance programs, such as Medicaid or SCHIP.
2) As currently proposed, the tax credit will *not* improve the opportunity for coverage for those people who are currently unable to obtain insurance in the individual market due to a combination of age, chronic illness or other expensive medical needs—who might otherwise be able to afford a standard insurance package.

The Benefits of a Health Insurance Tax Credit

In addition to opening the door to coverage for at least a portion of the uninsured, a tax credit for individuals to purchase health insurance offers some desirable potential consequences. These are: 1) greater equity between the effective cost of insurance purchased on the individual market as compared to employer-sponsored coverage; 2) improved choice for individuals among health insurance plans; and 3) a potential improvement in the affordability of individual coverage.

Equity—Under current law, individuals (those who aren't self-employed) purchasing coverage on the individual market must pay taxes on the income used to purchase insurance, whereas those who have employer-sponsored coverage escape taxation on the benefit. With a tax credit, individuals would receive some offset to their income taxes analogous to the benefit received by those in the group market.

Choice—By offering a tax credit to purchase individual coverage, the penalty for a person opting out of his or her employer plan is lessened. Assuming the individual is not otherwise in the "uninsurable" category, this would potentially increase the number of plans from which an individual could choose.

Potentially Improved Affordability of Individual Coverage—Assuming the tax credit is large enough to encourage enough people to purchase coverage, the greater numbers of new enrollees would serve to help plans spread risk and improve their medical loss ratio in their individual products. If sufficient numbers of new enroll-

[i] Kaiser Family Foundation, "State Health Facts On-line."

ees—estimates suggest as many as 18 million—armed with a tax subsidy enter the individual market, market forces could serve to make such coverage more affordable.[ii] This would be enhanced by options for pooling risk in state employee benefit programs and other programs (SCHIP, etc.) as proposed by the Bush Administration.

Problems with a Health Insurance Tax Credit

While a health insurance tax credit offers some potential benefits, it also has some weaknesses as an approach to significantly reducing the number of uninsured. First, in order for a tax credit to stimulate significant take-up rates by low-income persons, it must cover between 25 and 50 percent of premium costs.[iii] The level of subsidy proposed by the Bush Administration, based on research of average premiums in the individual market, would not achieve that level for most people outside the large group market. Second, creating such a tax credit is administratively complex and raises questions about how subsidies would be determined and distributed. Third, individuals with chronic illness or other medical conditions that require expensive treatment and/or pharmaceutical costs find individual coverage prohibitively expensive or simply not available at present.

Achieving Affordability—Professor Mark Pauly of the Wharton School at the University of Pennsylvania, a proponent of tax credits, noted in testimony before the House Ways and Means Subcommittee on Health last year that "there is a very pronounced 'notch' or 'threshold,' below which credits have small effects and above which effects become much larger. For example, we estimate that a credit of half the premium for an average policy will reduce the number of uninsured by half, whereas a 25 percent credit will only affect a few people, primarily those who aren't wage workers."[iv]

According to research by the advocacy group Families USA, the average annual premium for individual coverage in four of the states we serve—Alaska, California, Oregon and Montana—ranges from $2,191 for a healthy, non-smoking 25-year-old woman to $5,280 for a healthy, non-smoking 55-year-old woman.[v] Based on these premiums, the Bush proposed $1,000 tax credit for individuals and $3,000 for families would likely fall short of meeting the 50 percent for even the healthiest individuals and families. Moreover, out-of-pocket costs, which can reach as high as $10,000, are not factored into this equation.[vi]

Professor Pauly, in his Health Subcommittee testimony, also bemoans the characteristics of the individual market: "The most problematic feature of proposals to make credits available for private insurance is the current rather unimpressive state of the private individual insurance market in the United States . . . the main problem in this market is that administrative costs are high." Pauly states that a significant number of new buyers in this market would likely increase quality and reduce risk screening and premium costs.[vii] However, there is no assurance that sufficient numbers would take up individual coverage at the level of the President's tax subsidy.

Complexity in Administration—Ensuring that recipients of a tax credit aimed at low-income individuals and families utilize the credit in large numbers requires that it be designed to account for a range of circumstances. For example, the tax credit, even if designed as a refund, must be available to recipients such that they have enough liquidity to pay monthly premiums. Low-income families and individuals often don't have enough money available with each paycheck to cover the cost of premiums, even if they know they will receive a refund of part of the cost at year-end. Fluctuating income—a common characteristic of low-income workers—also may create problems in their ability to pay for monthly premiums. Addressing these concerns and others will place new burdens on the Treasury, which administers and enforces the federal tax code and would therefore be responsible for administrating the tax credit. Finally, such an approach would add complexity to the already Byz-

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[ii] Statement of Mark V. Pauly, Ph.D., Professor, Health Care Systems, Wharton School, University of Pennsylvania, Philadelphia, Pennsylvania. Testimony before the Subcommittee on Health of the House Committee on Ways and Means, April 4, 2001.

[iii] Pauly, testimony before the Subcommittee on Health of the House Committee on Ways and Means, April 4, 2001.

[iv] Pauly, testimony before the Subcommittee on Health of the House Committee on Ways and Means, April 4, 2001.

[v] FamiliesUSA, "A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured," September 2001.

[vi] FamiliesUSA, September 2001.

[vii] Pauly, testimony before the Subcommittee on Health of the House Committee on Ways and Means, April 4, 2001.

antine tax code. The sheer complexity of the tax code may serve as a barrier to take-up rates on the part of low-income individuals and families.

Access to Coverage for "Uninsurable" Individuals—The effects of market forces and phased-in options to allow the tax credits for purchasing coverage through state-sponsored purchasing groups or government employee programs will likely improve access for some of the uninsured. However, many people eligible for the tax credit will remain uninsured under the Bush proposal due to their poor health status. Even those who are currently able to enroll in a state high-risk pool face prohibitive premium costs. For example, the annual individual premium range for Washington State's high risk pool is $1,370 to $8,734 per person; in Oregon it is $1,620 to $6,120 per person; in California it is $1,300 to $10,284 per person; in Alaska it is $1,394 to $12,188 per person and in Montana it is $2,127 to $5,762 per person.[viii]

In a recent research paper on state high-risk pools, Lori Achman and Deborah Chollet of Mathematica Research, Inc. conclude that "the small size of pool enrollment is attributed to their high premiums and, in many states, to the very limited benefits they offer. Moreover, because all states must find ways to cover shortfalls between premiums earned and costs incurred, some have capped enrollment; most do not conduct extensive advertising or outreach to attract enrollment."[ix]

Conclusion: Tax Credits Combined with Public Program Expansion

In our view, tax credits for health insurance are one piece of what should be a package of legislative proposals designed to bring about incremental reductions in the number of uninsured in the United States. Because the Bush tax credit proposal is likely to prompt only a fraction of the uninsured to purchase coverage, we urge that Congress and the White House consider one or more of the following additional steps to expand coverage for the poorest and the most difficult to insure. These are:

- **MEDICAID/CHIP EXPANSION.** Expand eligibility under Medicaid and/or CHIP for all persons below 150 percent of the Federal poverty level, including legal immigrants. States should have the option of implementing this expansion either as an extension of the existing Medicaid program or as a separate program with a private insurance benefits package (e.g., subject to minimum benefits requirements).
- **EXPANSION OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).** Permit individuals without access to employer-sponsored coverage to obtain benefits through FEHBP. FEHBP participating plans are required to cover all eligible applicants without pre-existing condition exclusions regardless of health status during annual open enrollment periods for persons who have maintained continuous coverage for at least one year. Allowing individuals to access this risk pool would reduce their premium burden and further spread risk for the FEHBP.
- **OUTREACH AND ENROLLMENT FOR MEDICAID/CHIP COVERAGE.** Remove barriers to enrollment in Medicaid and CHIP and expand outreach to special populations.
- **FUNDING TO STRENGTHEN THE HEALTH CARE SAFETY NET.** Even with significant improvements in levels of coverage, many will continue to go without health insurance for various reasons. As such, it is critical that funding be increased for community health care safety net providers. We recommend Congress and the White House provide $500 million annually in grants to local communities to enhance collaboration and cooperation among safety net hospitals and clinics.

We applaud the members of this committee and the White House for pursuing in earnest strategies to improve access to health care and basic social justice for our nation. We look forward to working with our Congressional representatives and the White House in this vital endeavor.

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[viii] Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc., "Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools," August 2001.

[ix] Achman and Chollet, August 2001.